Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Doris Francis Baker Novembe 010 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4b. City, 4c. County of Death Battimore maruland Cita 9. Birthplace (State or Foreign Country)
MD (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Oct. 12, 1938 Year I If Under 24 Hre Social Security Number
 216-34-4849 Hours Days 1 □ M 2 □XF Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore MD Gwynn Oak 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 21207 10e. Street and Number 6516 Dogwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 11. Marital Status 1 □Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Switch Board Operator <u>Hospit</u>al 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norbert Smith Edna Hopkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6516 Dogwood Rd. Gwynn Oak, MD 21207 Charlene Baker (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Western Star Cem. 11/25/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wesley Chavis, JR. FH 2007 Eastern Ave. Baltimore, MD 21231 23a. Part I. Effer the disease shock, or heart failure. Approximate Interval Between Onset and Death nplications that caus death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final P disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

Department of Health and Mental Hygiene. Important: if item 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examble in it

Pages 1 and 2 should be in nent of Health and Mental

Baltimore,

P.O. Box 68760,

Division of Vital Records,

filed within 72 hours after death with the

Be Completed by Funeral Director

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Examine

Physician/Medical

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Be Completed

burial-tran and physician the attending pl for use signed to be deta page 2 should

funeral director,

or Attending Physician: The law requires that the death certificate be executed death. filled in by the

Medical Certification: To within 24 hours after deatl To the Funeral Director: Hospital completely

> 31. Date filed (Month, Day, Year, State Registrar

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number 031865

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 0

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed caus f death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ²23,2009 Month **Physician** 7:45 P November Bernadine C. Bass /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Berlin Worcester 56 Mystic Harbour Blvd. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 □ M 2 🖾 F Yrs. Director 78 1931 213-26-6172 January 26, Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it will be matted at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 56 Mystic Harbour Blvd. 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify <u>۾</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dermatology Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank J. Getek Josephine R. Blachowicz ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 Mystic Harbour Blvd. Berlin, Maryland 21811 Rosser Bass (husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/30/2009 St. Stanislaus Baltimore, Maryland Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, MD. 21222 Dundalk, Inc. 23a. Part 1. Enter the disease, or complications that caused the death Immediate Cause (Final a. AmxioTrupta **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) P.0. 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate of Vital 1 □Yes 2 N 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Medical Certification: To 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) title of certifier

State Registrar

DHMH 17 Rev 1/2001

10324 OLD OCETALLIT

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWIN CODMEDANIO

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1-State Registrar Certificate of Death Reg. No.2 1 1 9 3 8 1 1 3													
Registrar 1. Decedent's Name (First, Middle, Last)						Cer	tificate of L	Death			eg. No	9 3	8003
	Physicia		1. Decedent's Name (First, Wildlie, La.	Ida	R		Burns			Month	Day Ye	ar	me of Death
1	Medic \ Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or	Location of (<u>ovembe</u>	4c. County of E		U.UUA
_)		2809 A. Willow	Avenue			Edgem	ere			1	ore Co	٠.
	Funeral		5. Social Security Number 6. S	Sex 7. Ag ☐ M 2 □XF		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Min.	Date of Birth (Month, Day, ' ugust	Year) g.	Birthplace (S Country)	tate or Foreign
	Director		219-14-7307 Usual Residence of Decedent		86	115.			A	ugust	18, 1923	Mary	Land
	land shov	ţor	10a. State 10b. County		10c. City	, Town or Lo	ation					10d. Insi	ide City Limits
	Mary 28a-i notifie	irec	MD Baltimo	re	Edg	gemere						1 [☐ Yes 2 🔀 No
	ith the	Funeral Director	10e. Street and Number				10f. Zip Code 21219			10	0g. Citizen of What USA	Country?	
	ems :	nue	2809 A. Willow A	12. Was Decedent			Vas Decedent of Hi	spanic Origin	n? (Specify	Yes or No-		merican India	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 Never Married 2 Mamed	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give		11	Yes, specify Cubar	n, Mexican, P	Puerto Rica	an, etc.)	Black, W	/hite, etc.	,
Ö	ours a	Completed by	3 🔀 Widowed 4 🗌 Divorced	Year or Dates.							Specify:	White	
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nd	filed tal Hy ad oth event	To Be	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (Fi	rst, Middle, M	aiden Surname)		
7	d Men marke matic	_	Joseph	Parise	2	1		Conce			Criv		
Ma	27 is		19a. Informant's Name/Relationship (7) Concetta Beam (daughter)			g Address (Street a A. Willo				City or Town, State, • Marylar		219
Baltimore, Maryland 21215-0036	1 and of Hea item other		20a. Method of Disposition			ace of Dispo	sition (Name of	1	Date		20c. Location - City		
imo	Page nent o ant: If ury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State fy)	' I		ervice Co		2/01/	2009	Towson, 1	Marvla:	nd
3alt	permit. Page 1: Department of I Important: If it any injury or or		21. Signature of Funeral Service Licens	see	1222						uneral Ho		
_		1511	1 5 7 7 C				922 Wise				D. 21222		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	d the death e.	. Do not ente	r the mode of dying	g, such as car	rdiac or re	spiratory arres	st,	Interva	ximate al Between and Death
	Medical		disease or condition resulting in death)	a. Chan Due to (or as	2 conseque		tructive	· PU	mon	37 6	Disease	7	1ears
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3760	ficate g phys			d								\pm	
39 ×	ath certifica attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth			Ectopic pregnancy	v			23d. Date of	delivery	
P.O. Box 687	e deat the at hed fo	Physician/Me	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5	Other (specify)				Month	Day	Year
Ö.	requires that the de been signed by the s should be detached	y Ph	Part II. Other significant conditions of	ontributing to death b	out not resu	Iting in the u	nderlying cause give	en in Part I.	T	23e. Did toba	acco use contribute	e to the causo	e of death?
S,	uires t n sign ald be	ed by								1 \square Yes	s 2 🗆 No 3 🗆	Probably	4 LUnknown
Soro	w req	plet								24a. Was an		autopsy find	ings available
Division of Vital Records,	The law ate has page 2 s	Completed								autopsy perform 1 Yes 2	ned? death	to completion 1? Yes 2 🗆 No	
ta	hysician: The nis certificate I director, pag	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death ((Check onl				
Ž	Physi this c	<u>و</u>	1 Yes 2 No 27. Manner of Death	1 Inpati		R/Outpatien		4 📙 Nursi			nce 6 Other (Sp	secify)	
0 0	nding I tth. : After s funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	y, Year)	injury	28c. Injury work? M 1 🗆	at ? Yes 2 □ No	- 1	Describe how	v injury occurred		
isic	I or Attendi after death Director: A d in by the f	Certificate:	3 Suicide 6 Could not b	28e. Place of Inju		ne, farm, stre			28f.		eet and Number or	Rural Route I	Number,
<u>≤</u>	ital or urs aft ral Dir lled in			building, etc						City or Town,			
	Hosp 24 hor Fune eted fi	Medical	(Check 2 L Medical Exam	sician: To the best of iner: On the basis of e	xamination	and/or investi	gation, in my opinior	n, death occur	irred at the	time, date and	place, and due to the	he cause(s) an	nd manner stated.
7	To the Hospital or Attending Physician: The law requires that the death certificate be executed within L4 hours after death. To the Funeral Director, dether this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Σ	only one) 3 L Certifying Nur-	se Practioner: To the	pest of my	knowledge, d	eath occurred at the 29c. License	time, date an number	nd place, ar	nd due to the c	ause(s) and manner	as stated. onth, Day, Yea	ar)
			Shaw J.	he Cent	MO)	03	876	62		Nov .	30,2	2009
			only one) 3 Certifying Num 29b. Signature and title of certifier 30. Name and address of person who of 31. Date filed (Month, Day, Year)	completed cause of d	eath (Item 2	23a) (Type, P	int) Sharo Limore,	"Md.	Me C	229	de		
	Stat Registra	e	31. Date filed (Month, Day, Year)	9 3. Registra	ar's Signatu	re bar	Kal		<u> </u>	/			
	riegisti a	٠	UEP II Lease	- Cin		//							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8-50 M EVELYN MAE BLOOM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 Dr F Months Month, Day, Year Director 212-34-7942 1934 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3336 KESWICK RD 21211 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black White etc 1 Never Married 2 Married Completed by ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🛣 No Yes, Give Specify 3

Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH **HOMEMAKER** HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GEORGE HARMAN WITHERS MARY ELIZABETH WILCOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBRA KITTY LYNN BLOOM/DAUGHTER 2741 MILES AVE., BALTIMORE. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) ARDENT HANOVER, MD 21. Signature of Fun Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN BALTIMORE. AVE. 21231 23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on each e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician MAC disease or condition Medical resulting in death) Due to (or as a consequence Examiner 0 112 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No ed by the detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an .24 hours after deaun.

• Funeral Director; After this certificate I heted filled in by the funeral director, pagn performed Yes 2 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 3 🗌 only one) 29b. Signatu 29d. Date signed (Month, Day, Year) 38946

State Registrar 31. Date filed (Month, Day, Year)

Baltimore

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	State o	it Maryla		artment of F rtificate of a	lealth and N <i>Death</i>		giene2 (009	38005
1. Decedent's Name (First, Middle, Last) Physician Rose Brown									2. Date of De Month	Day	Year 2000	3. Time of Death
San	/Medid Examir		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, or	r Location of Death	lvovent		2009 by of Death	11:47 ^M
- 50			Good Samaritan H				Raltin			n/	~	
	Funeral Director		5. Social Security Number 212–34–6574 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔀 F	7. Age (In y	71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8-18-	th ly, <i>Year)</i> 1938	9. Birthpl Count	ace (State or Foreign try) M)
	yland		10a. State 10b. County		10c.	City, Town or Lo	cation				10	d. Inside City Limits
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	ith th	Dire	10e. Street and Number				10f. Zip Code	_		10g. Citizen of	What Count	ry?
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Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	5	Never Married 2 Marri Never Married 2 Marri Widowed 4 □ Divorced	Armed Fo	rces? 2 X No ve	1	rvas Decedent of H fYes, specify Cuba I∐Yes 2∭ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity reside No Rican, etc.)		ce - America ick, White, el fy: Africa	
2-0	72 hor	Completed	15. Decedent (Specify only highes	's Education		16a. Deced	tent's Usual Occup	ation during most of work	'na	16b. Kind of B	Business/Ind	ustry
121	within ane. than "	Idm	Elementary/Secondary (0-12)	College (1	-4or 5+)	Nurses	DO NOT use retired	d) most of work	ng	Children	's Host	itai
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Baltimore,	Pages tment of I tant: If ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	State	g Mamoria	natory or other plac LPark	12-4-C		Woodlawn	, MD	
Ba	permit. Page Department Important: It any Injury o		21. Sign, are of Funeral Service I	icensee M. W	Lyla	· 92	. Name and Addres 200 Liberty	ss of FacilityWyli. Road, Rand	e Fineral allstown,	Home P.A MD 21133	1. of B 3	altimure Co.
. The state of the	tificate be executed By Medical Examiner By Medical Examiner By Medical By	al Examiner	23a Part 1. Enter the disease, or shock, or heart failure. List of needlate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conse	equence of):	14	g, such as cardiac of	or respiratory a	rrest,		proximate Interval Between Onset and Death
, B0X	attendin for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No	4 ☐ Pregr	oirth 2 ☐ Fe nant at time o	etal death 3	Ectopic pregnancy	/		1	ate of deliver	ry Day Year
1	requires that the leen signed by the nould be detache		9 ☐ Unknown Part II. Other significant condition	9 Unkn	eath but not re			en in Part I.	23e. Did to	obacco use con	tribute to the	e cause of death?
o G	requir	ted	End-Stage	76677	(()	DISCUS e	<u> </u>		1 🗆 ነ	′es 2 No	3 ☐ Proba	ably 4 Unknown
r	sician: The law requires that the di certificate has been signed by the rector, page 2 should be detached	Completed by								rmed?	Were autopoprior to com death? 1 ☐ Yes 2	sy findings available pletion of cause of 2 □ No
VItal	Physician: this certific at director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		☐ ER/Outpatient	Othe	26. Place of Death				
	Io the flooptial or Attending Physician: The living 124 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investige 3 Suicide 6 Could n 4 Homicide determin	28a. Date of (Mont) ation of the 28e. Place	of Injury h, Day, Year)	28b. Time of Injury	28c. Injury Work	4 □ Nursing Holi / at ?? Yes 2 □ No	28d. Describe h	now injury occur	red	
^ :	e Hospita 124 hours e Funeral letely filled	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the examiner: On the ba and manr	asis of examil	nowledge, death nation and/or inv	occurred at the tin restigation, in my op	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and m date and place,	anner as sta	ated. the cause(s)
	Nithir To th comp	Me	29b. Signature and title of certifier	. 4	But	home	29c. License	FS70		29d. Date signe	ed (Month, D	27,2009
			30. Name and address of person w	ho completed caus	e of death (Ite	em 23a) (Type, F	Print) L Rev	ier bli	d B	Paltin	ne	
	Stat Registra	٠ _ا	31. Date filed (Month, Day, Year) DEC () 1, 200	9 Server	egistrar's Sigr	nature	g					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		4	For State Registrar	Otato of War	•	Certificate of L	Death	Reg	2009	38006
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic		Stanley T. Bitze:	r				November	18, 2009	2:40 PM M
	Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County of Death	
			Hospice of the Cl				hicum		Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 1215-30-9248	7. Age ((In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 6,	Year) Cou	pplace (State or Foreign Intry) 1and
_	- or		Usual Residence of Decedent 10a State 10b County	1	Oc. City, Town	or Location				10d. Inside City Limits
	show	_	MD Anne Aru		Pasade					1 □Yes 2X No
	Ba-f	ecto				10f. Zip Code		10	g. Citizen of What Co	untry?
	ith th	ä	10e. Street and Number			21122		"	USA	,
	s 23s	eral	8326 Woodland Rd.	12. Was Decedent Ev	er in IIS		lispanic Origin? (Sr	ecity Yes or No-	14. Race - Amer	rican Indian,
	item item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1∑Yes 2☐ No		Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, White	, etc.
36	rs aft	by	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:	1954	1 □Yes 2 🖾 No	Specify:		Specify: wh	
ğ	2 hou		15. Decedent's Educ	cation	16a. [Decedent's Usual Occup	nation	ing 1	6b. Kind of Business/l	ndustry
215	i within 72 hours after death with the Marylan jene. r than "natural", or items 23a or 28a-f show the Medical Examirer must be nutflied at	Completed	(Specify only highest grade		. I	Give kind of work done life. DO NOT use retired	d)	ing		
2	d witi	Son	Elementary/Secondary (0-12)	College (1-4or 5+)	p.	lumber				
ng	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show arumatic event, the Medical Evantract must be rutified at	e	17. Father's Name (First, Middle, Last)	1 d da m a na				_{e (First, Middle, M} oecca And		
<u>X</u>	Ment Ment arked atic e	ို	William Jennings E							
a	is 1 and 2 should be to Health and Mente item 27 is marked other tranmatic every.	- 83	19a. Informant's Name/Relationship (Type			Mailing Address (Street				
2	ss 1 and of Health item 27 r other to		Dawn Kostick/daugh	iter		94 Duvall H			Oc. Location - City or	
Baltimore, Maryland 21215-0036	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery	Disposition (Name of r, crematory or other place	ce)	-	,	,
Ħ	permit. Pages Department of Important: If it any Injury or o		4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		. // .	22. Name and Addre	ess of Facility	1. 655 W	Baltimore	Street
ä	Dep Imp any		21. Signature of Funeral Service License Ronald S. Wa	Mel Tricec	tor	Baltimore,			Dartinore	
			25a. Parl 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the	he death. Do n	ot enter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediat Cause (Final			: Bigner	Disens 4,	Bletnal +	feiler 1	Onset and Death
7	/Medical		disease or Indition resulting in	Due to (or as a	consequence o		,			
	Examiner		Sequentially list conditions							
	70 #≡	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence o	f):				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	CONSEGURACIO	f\·				
60,	icate be executed physician and the burial-transit		100 stating in additing and	Due to (or as a	consequence o	·)·				
68760,	tificate be executed ig physician and as the burial-transit	Physician/Medical		l						
		/Me	IF FEMALE:	23c. If yes, outcome o		_			23d. Date of de	livery
Box	death cer e attendin d for use i	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		Month	Day Year
o	v requires that the dispense signed by the should be detached	ysi	9 Unknown	9 Unknown						
σ,	The law requires that the ate has been signed by th page 2 should be detache	by PI	Part II. Other significant conditions con	ntributing to death but	not resulting in	the underlying cause gi	ven in Part I.	23e. Did tob	pacco use contribute to	
5 S	quire; en sig uld be	g p	Derentia					1 □ Ye	s 21 No 3 P	robably 4 Unknown
Vital Records,	aw re	Completed						24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
æ	The la	E						perforr		·
ita	ian: rtifica stor, p	BeC	25. Was case referred to medical				26. Place of Dea	ath (Check only on	e)]	050-68
	hysician: The law his certificate has t I director, page 2 sl		examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatier	nt 2 🗆 ER/Out	tpatient 3 □ DOA Ot	her: 4 Nursing H	lome 5 ☐ Reside	ence 6/BOther (Spe	ecify) Touse
0	ding Phy h. After thi funeral d	uo.	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	y 28b. T Year) Ir	njury Wo		28d. Describe ho	ow injury occurred	
Sio	tendi eath. or: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be]Yes 2 ☐ No	Of Location (C)	treet and Number or F	tural Pouto Number
Division of	l or Atten after deatl Director:	Certification: To	4 Homicide determined	building, etc.	ry - At nome, far . <i>(Specify)</i>	m, street, factory, office		City or Town		urai Fioule Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier Certifying Phy	sician: To the best o	f my knowledge	, death occurred at the	time, date and plac	e, and due to the d	cause(s) and manner	as stated.
	the Ho iin 24 t the Fu ipletely	Medical	one)	iner: On the basis of and manner stat		d/or investigation, in my				
_	To the within 2 To the comple	Σ	29b. Signature and title of certifier	7/	2	29c. Licen	se number	7	9d. Date signed (Mon	CAZ 7/1.9
	7	(1/17	100			1/5 5 1		V Wen or	1) 100/
	(6)	(30. Name and address of person who c	e Lun M	eath (Item 23a) ((Type, Print)	Jel Or	se Gle	Dunn M	2-2106/
		ate	31. Date filed (Month, Day, Year)	3. Registra	r's Signature	Land	- 1 - V - V - V	7) 1	
	Regist	rar	HIT I, II I LUV	V KRAPINA	1 1. 4	THE COLUMN TO SERVER				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9, State of Maryafid / Dependent of Health and Mentall Jegienes 9812/14/09 JH amend #5 Per FH G898 12/30/09 JH Death Reg. No. 2009 38 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Pay 2009 2:11 Рм Rachel M. Bertrand Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton Southern Maryland Hospital 5.578 S98 12994 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jay, Y 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 😿 I Hours **Director** 34 Maryland Usual Residence of Decedent 28a-f show 10a. State 10h County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges 1 Yes 2 X No Forestville 10e Street and Number ö 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 20747 USA 1920 Richie Road death v 11. Marital Status - unk 12. Was Decedent Ever in U.S. Armed Forces? **U.D.K.** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married "natural", or ģ 1 ☐ Yes XX No If Yes, Give Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: black Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Private accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unle Randolph S.Bertrand Rose Marrie Duhaney 19a. Informant's Name/Relationship (Type, Print) / mother Southern Maryland Hospital 195 win Astres Gretenochtmberr Burel Butte Number City Toyo fixto Code) 7503 Surratts Road; Frince Georges, Maryland 3altimore, 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) injury (Donation 5 11 or Heritage Memorial Cem. 12/5/2009 Waldorf, MD. 22. Name and Address of Facility Hodges & Edwards F. H. Ronald 3910 Silver Hill RD , --- Suitland, MD 20746 23a. Part 1. Enter the disease, or competications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease condition resulting in eath) Physician Medical Medical Examiner m Sequentially list conditions if any leading to immediate Examiner в ползеоналов об cause. Enter Underlying that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death the g 🗌 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 ☑ No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D19889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ba mp-UTHEEN . Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, N Month 2000 Samue Physician /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future Care - Sandtown Baltimore Baltimore 9. Birthplace (State or Foreign Country) Baltimore 5. Social Security Number 216-62-2177 7. Age (In yrs. last birthday) 6 Sax **Funeral** 1⊠M 2□F Director 51 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show itam 27 is marked other than "natural", or items 23a or 28a-f shov other traumstic event, the Madical Examinar must be notified at 1X Yes 2 No Baltimore MD Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21217 1000 N. Gilmore Street Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?unk 1 ☐ Yes 2 ☐ No 11. Marital Status unk permit. Pages 1 and 2 should be filed within 72 hours after c. Dependment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item sny injury or other traumetic event, the Madical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1000 N. Gilmore Street; Baltimore, Maryland 21217 Future Care - Sandtown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☒Other (Specify) in state irector S. Wald 21. Signature of Funeral Servi State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physicien end detached for use as the burial-transit The law requires that the death certificate be executed 00 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown cete has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 1 ☐ Yes 1 Yes 2 No : After this certification, i To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending after death. 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d Funaral Direct filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Funa completely fi Medica (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) levell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Villie S. MVEL 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #31 Rear Dyn G898,12/15/09, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 38009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician MA 2080 2009 NoJ 97(-/Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** toward 60 low Ó 8. Date of Birth (Month, Day, Tune 14, Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number **Funeral** Year) 1945 Days Hours 1 □ M 2 🛛 F 176-36-4934 Pennsylvania 64 June Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int; If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual be notified at once. 10b. County 10a. State 1 ☐ Yes 2 ▼ No MD Howard Woodstock Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21163 USA 10801 Enfield Dr.; Apt 426 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) library assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Palision Mary Zatek ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10801 Enfield Dr.; Apt 426; Woodstock, MD 21163 Louis Babnigg/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 3, 2009 Baltimore, Maryland

22. Name and Address of Facility Cremation Society Of Maryland

259 Frederick Road Baltimore, MD 21228

Earlimore, MD 21201 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 4 Donation 5x10ther (Specify) in State 21. Signature of Funeral Se vice Licensade Approximate Interval Between Onset and Death 21a. Part I. Enter the dis-se, or compil ations hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate ause (Final disease or c dition resulting in de **Physician** yerhythmin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine /ro the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ■ No 24a Was an autopsy performed? Yes 2 \Box 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2XER/Outpatient 3 □ DOA nours after death.

neral Director: After this villed in by the funeral di Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Floute Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0054484 16, 2009 Name and address of persor who completed cause of death (Item 23a) (Type, Print) Colombia, MD 21094 5711 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** BRISCOE BON DA MOVEM BER /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SOK SECOURS Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbelink 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Days Months Hours Min. 1⊠M 2□F **Director** Jan 10, 1963 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Baltimore Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 401 E. Madison Street 21202 USA itеms 23a Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 Specify: black 1 ☐ Yes 21 ☐ No Completed by Hygiene. other than "natural", 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation un 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College_(1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other this any lijury or other traumatic event, 1 and 0002e. unk 17. Father's Name (First, Middle, Last)unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bon Secours Hospital 2000 W. Baltimore Street; Baltimore, Maryland 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Conner (Specify) In State 21. Signature of Funeral Service RODALO Licenses State Anatomy Board; 655 W. Baltimore Street Director Baltimore, Maryland 21201 2 a. Pal 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ORONA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of): Hospital or Attending Physician:. The law requires that the death certificate be executed STAGE Due to (or as a consequence of) Box 68760. physician BETES Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) P.O. 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, cate has been si page 2 should b 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 □ Yes 2 2 No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA s after death.
I Director: After this of in by the funeral d 27. Man of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospius.
within 24 hours after
To the Funeral Dir Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00030355 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOX SECOURS 0

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Barcliff November Marian Holsev 2T 200° /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore 7440 Millwood 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 X F Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examinating the Indian once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 74to Millwood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: Black 2 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Guidance Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peaker HOLSEY Augustus ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Prin Gleneagle Road Battimore Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1203109 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. - Fareral SVG 21. Signatur of Funeral Service Licensee 8728 Liberty Road Randall town MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nouz **Physician** Nyoca /Medical Due to (or a sa consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 2 1 No 1 □ Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 2 2 □ No 1 ☐ Yes 2 🗷 No 1 ☐ Yes After this certificate 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Medical Certification: To 27. Mann of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintened at the time, date and place, and due to the cause(s) and manner stated.

Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

State

29b. Signature and title of certifie

31. Date filed (Month, Day,

MACINON

Quas

address of person who completed cause of death (Item 23a) (Type, Print)

2700

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/Medical Examiner	Physiciar	ì
Examiner	/Medica	
	Examine	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Medical Evaluation of the traumatic event, its Medical Evaluation of the traumatic event.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Stat Registra

1 - State Registrar Certificate of Death Reg. No. 2009									000.		
	Decedent's Name (First, Middle, Last)					2. Date of Deat		.,	3. Time of Death		
an	PERCY S.	BRAN	HAM			Month I I	23 ^{Pay} 2	0ŎĠſ	1:25 P M		
al	4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location	of Death		4c. County of Death				
er	304 17th Avenue		Brookly						indel		
		(In yrs. last birthday)	If Under 1 Year			8 Date of Birth			pplace (State or Foreign		
	217-12-0044 1XI M 2 F 87	(In yrs. last birthday) Yrs.	Months Days		Min.	8. Date of Birth (Month, Day, May 15,	Year) 2 2	Col	untry) VA		
	Usual Residence of Decedent			1		1107 109	- /				
		10c. City, Town or Loc	cation						10d. Inside City Limits		
5	MD Anne Arundel	**	oklyn Pa	rk		1 □ Yes 2 🛣					
ect			· ·			1.					
Dir	10e. Street and Number 304 17th Ave.		10f. Zip Code 212	25		1		g. Citizen of What Country? USA			
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Ine	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13. V	Vas Decedent of f Yes, specify Cut	Hispanic Or oan, Mexica	rigin? (Sp	ecify Yes or No- Rican, etc.)		ce - Amei	rican Indian,		
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d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			0,000			Specia	y.	WILLCO		
etec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occu	pation	st of worki	ina	16b. Kind of E	Business/I	ndustry		
du	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done OO NOT use retire		HVIN	9	D	_ 1			
8	5	Ele	ectricia	n			Railr	oad			
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)			18. Moth	er's Name	e (First, Middle, N	Maiden Surnai	me)			
	John C. Branham 19a. Informant's Name/Relationship (Type. Print) Macie Etta Branham / Wife 20a. Method of Disposition 12Berrial 2 Cremation 3 Removal from State 12Berrial 2 Cremation 3 Removal from State										
	4 Donation 5 Other (Specify)	9									
	21. Signature of funeral Service Licensee	ress of FacilityKirkley-Ruddick Funeral Home PA 1 Hwy SE Glen Burnie MD 21061									
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	23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not ente	er the mode of dy	ing, such as	s cardiac	or respiratory arre	est,		Approximate Interval Between		
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þ	Part II. Other significant conditions contributing to death but	not resulting in the un	ideriying cause g	ven in Part	I.				the cause of death?		
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plet	Cardiango part	1				24a. Was a			topsy findings available		
E						autops	ned2/	death?	completion of cause of		
Be Completed by Physicia	25. Was case referred to medical			ge Di-	a af D "		No No	1 ∐Yes	2 No		
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틛	4 Homicide determined 28e. Place of Injur building, etc.	y - At home, farm, stre <i>(Specify)</i>	eet, ractory, office			28f. Location (St City or Town	reet and Num 1, State)	ber or Ru	ral Route Number,		
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cal	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner)	my knowledge, death	occurred at the	time, date a	ath occur	and due to the c	ause(s) and nate and place	nanner as	stated. to the cause(s)		
Medical Certification: To	one) and manner state	ed.									
Σ	29b. Signature and title of certifier		29c. Licen	se number		2	9d. Date sign	ed (Montl	n, Day, Year)		
	· CV MA		00	55	06		11/	28	1209		
	30. Name and address of person who completed cause of dea	ath (Item 23a) (Type. F	Print)			21		- /	. /		
	Textines un ?	22/ /	20/01	Sh	cet	Jol 1	me	17	12/125		
e	31. Date filed (Month, Day, Year) 32. Registrar	's Signature									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear 09:15/4 Bernard N. Barnes towe MBER 20091 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BAL TIMO HENES HUSPITA1 N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Months 1 □ M 2 □ F 217-38-9547 67 Sep 20, 1942 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 □ No Gwynn Oak Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21207 1719 Langford Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Milford Mill Lumber Truck Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Corine Butts Gilbert Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1719 Langford Road Baltimore, Maryland 21207 Ernestine Barnes 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/18/09 Baltimore, Maryland 4 Donation 5 Dother (Specify) Lorraine Park Cemetery & 21. Signature of Funeral Service Licen-22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Do not enter the mode of dving, such as cardiac or respiratory arrest, Immediate Cause (Final RESPIRATOR disease or condition resulting in death) Due to (or as a consequence of): MELLMON if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 1 ☐Yes 2 ☑No 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred Mann of Death

Examiner burial-1 ed by the attending physician detached for use as the buria P.O. Box 68760 W BARIN signed by the sign of the sign Records, page 2 should has certificate Division of Vital Physician: 24 hours after death. Funeral Director: After this

Attending

Hospital or

To the within 2

Examine Physician/Medical 2 Completed Be ၉

Certification:

Medical

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d other than "natural", or Items 23a or 28a-f sho event, the Medical Examinar must be notified at

72 hours after

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other tweether the page 1 injury or other the page 1 injury or other tweether tweether tweether the page 1 injury or other tweether tweether the page 1 injury or other tweether twee

Physician

/Medical

Saltimore, Maryland 21215-0036

25.	. Was case referred 😿 medica
	examiner?
	1 ☐ Yes 2 ☑ No
-	. /

atural 2 Accident

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMARE

29a. Certifier (Check only

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

CATOM

29b. Signature and title of certifier

MUS

29c. License number

29d. Date signed (Month, Day, Year)

(V 31. Date filed (Month, Day, State

THERESOH MO 900 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark

Registrar

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			For State Registrar	State of N	1arylan	d / Depa <i>Cer</i>	ırtment <i>tificate</i>	of H	ealth a eath	and M	lental Hy	giene Reg. No	200	9	380) 4
An.	Physicia Medic		1. Decedent's Name (First, Middle, I Edith M. Barker				_				2. Date of De Novembe		, 20°C	j [*] 9	3. Time of 8:12	Death Рм
4	Examin	er	4a. Facility Name (If not institution, g Gilchrist Center			re	4b. City, T		ocation o	f Death			County of D			
	Funeral Director					ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Bir (Month, Da		920	Birthpla Country	ace (State or Mary 1	Foreign and
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9036	регитіt. Page 1 and 2 shou d be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates.	?	1	Vas Decede Yes, specif			in? (Spec , Puerto F	cify Yes or No- Rican, etc.)	- 1	14. Race - / Black, V Specify:	America Vhite, et Whi	c.	
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// Maryland 21215-0036	Id be filed wi Mental Hygis arked other atic event, t	To Be (17. Father's Name (First, Middle, Las Raymond E. Barke	st)		reache	r / Gu i		18. Mothe	r's Name	selor Public Schools Name (First, Middle, Maiden Surname) e V. Schaeffer					
// Mar	nd 2 shou ealth and n 27 is m		19a. Informant's Name/Relationship Nancy Boyer	/ (Type, Print) / persona	ıl rep	19b. Mailin 6 Wil	g Address (derfi	Street an eld	Ct.;	r or Rural Lut	Route Numbe hervil	er, City or	Town, State	e, Zip Co)93	ide)	
8:16 F/ Baltimore, I	Page 1 an πent of Η. ant: If iter ury or oth		20a. Method of Disposition 1 XI Burial 2 □ Fremation 3 4 □ Donation 5 □ Other (Spe	Removal from State	e ce	lace of Disposemetery, crem	atory or oth		1	2/4/	ate 09		ocation - Cit timore	-		
8	permit. Departi Import any inj		21. Signature of Funera Service Live	Clerk			Name and		,		Home,	Inc			ork Ro , MD 2	
4014	Physician/ Medical Examiner	ıer	23a. Part 1. Enter the disease, or or shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or as	ne. O Ma s a consequ	rence of):	r the mode	of dying,	Such as o	eardiac or	respiratory ar	rest,		l i	Approximate nterval Betw Onset and D	een eath
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Ed. 4.	the death certific by the attending ached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of d	death 3	Ectopic pr Other (spe						23d. Date o Month			ear
्र व.	uires that in signed uld be dei		Part II. Other significant conditions	s contributing to death	but not resu	ulting in the ur	nderlying ca	use give	n in Part 1.		1				cause of dealbly 4	- 1
2rKer Records,	The law ate has page 2	Completed									24a. Was auto perfo 1 \(\sum \) Yes	psv	prior	r to com	y findings av pletion of ca	
eta Division of Vital	<u>₹</u> % □	Certificate: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of inj (Month, D	ury	ER/Outpatien 28b. Time of injury		Other: c. Injury a work?	4 ∐ Nu	rsing Hon	only one) ne 5 Resid 8d. Describe h			pecify)	Bilch	rist
Divisi	tal or Att irs after d al Direct		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of In	jury - At hoi tc. <i>(Specify)</i>		et, factory,	office		2	8f. Location (8 City or Tow			Rural Fi	oute Numbe	ır,
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying N	hysician: To the best our inner: On the basis of urse Practioner: To the	examination	ı and/or investi	gation, in m	y opinion	, death occ	curred at 1	the time, date a	and place,	and due to	the caus	e(s) and man	ner stated.
	vitil To		29b. Signature and title of certifier	l mi			29c, 1	License r	number	f		29d. Dat	te signed (M	onth, De	y, Year)	
	4		30. Name and address of person wh	o completed cause of	death (Item J. Cho	23a) (Type, Pr	int) St.	Su	ife1	410	5, Ba	PE	mort	, M	1) 212	204
	Stat Registra	.~	31. Date filed (Month, Day, Year)	2009 32. Regist	rar's Signati	ure).	arke				/			1		

Ronald Russell B		Fiedse Tyl	ate of Mary	land / De	epartm	ent of l	Health	and N	viental I		a. No	21	ากจ	38	n I
	R	eqistrar . Decedent's Name (First, Midd	le Last)		Jeruno	ale or i	Jean			2. Date of De			3.	Time of Death	- 1
Physicia Medical Examin				MIIKE V	CD					Month Novembe				1223 hrs	
		RONALD RUSS la. Facility Name (if not institution)	on, give street and	number)	OI/	45	. City, Tow	n, or Loc	cation of Dea	ath		c. County of I	Death		
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Director	- 1	218-68-5218	1 X M 2	F 52		Yrs.	Months	Days	Hours N	July	6.	1957	Mary	land	
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with the Maryland s 23a or 28a-f show a e notified at once	Director	10e. Street and Number					10f. Zip Co	ode			10g. Citizen of What Country?				
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with	교	11. Marital Status	12. Was	Decedent Ever d Forces?	in U.S.	13. Was	Decedent	of Hispa Juban, M	nic Origin?	(Specify Yes or I erto Rican, etc.)	1 0-	14. Race White,		Indian, Black,	
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12 Id be Aenta narke even	e Be	19a. Informant's Name/Relation	ship (Type, Print)	1	9b. Mailing	Address	(Street a	and Number	or Rural Route	lumber,	City or Town	State, Z	ip Code)	==7
Shou and N and Shou natic	F				- '										
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ı	20a, Method of Disposition	Henry R. Baum / Father 760 Willow Ridge Dr., York, PA 17404 a. Method of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)												
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Baltimore, permit. Pages I ar Department of Hee Important: If itel		4 Donation 5 Other 21. Signature of Funeral Servi		1	Garde	ens of	Falt ame and A	th Co	em. of Facility	11-28-09		місцік	JIC,	PHALYIA	11CL
Bal Depar Impo		21. Signatur of Funeral Service 23a. Part I. Enter the disease,	A. Ali	a solo		Mo	Comas	Fu	nerál	Home, P	.A.	on. M	210	009	
		23a. Part I. Enter the disease,	or complications	nat caused the	death. Do	not enter th	e mode of	dying, si	uch as cardi	ac or respiratory	arrest, s	shock, or hea	rt	Approximate I Between Ons	
Physician Maci⊏al		failure. List only one cau	se on each line.											Death	
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):													
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Box 68760 e death certificate be the attending physic of for use as the bu	Physician/Me	23b. Was decedent pregnant in past 12 months?	the 1 l	Live birth		2 Fe	tal death	3	Ectopic p	regnancy		Month	Da	ay Ye	ear
x 6 th cer ttendi	Sici	1 Yes 2 No 9	Intrasum 1	Pregnant at tim	e of death	5 O	her (Spec	ify)							
Bc ne dea the a	کیّ	Part II. Other significant cor	J,	Unknown	ut not resul	Iting in the	underlying	cause di	ven in Part	I. 23e. D	id tobac	cco use contri	bute to the	ne cause of de	ath?
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24a. Was an autopsy performed? 1 Yes 2 ✓ No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 ✓ No 3 Probably 4 24b. Were autopsy findin prior to completion of death? 1 Yes 2 ✓ No 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 25. Was case referred to medical examiner?								2	No						
A R An: T an: T ertific tor, p	Be C	25. Was case referred to med							0.0	heck only one)			7		
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Divi pital or ours afte	Certification:	4 Homicide		pecify) Gara											
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f		29a. Certifier 1 Certifyin	g Physician: To the	he best of my k	nowledge,	death occi	urred at the	time, da	te and place	e, and due to the irred at the time	cause(s	s) and manne d place, and	r as state due to the	ea. e cause(s)	
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0 + 3 + 3	×	29b. Signature and title of ce	rtifier				290		e number			November			
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		30. Name and address of pe							5	- ND 01001					
		Russell Alexander		ant Medica		ner 11			Baltimor	e, MD 21201					
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Registrar 2009 Aura A. Againet OCME															

		For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F rtificate of I			giene, Reg. No.	/	38016
Physic	an	1. Decedent's Name (First, Middle, Las Doris A. C					2. Date of De Month Dec.	ath Day	Year 2009	3. Time of Death 5:57 a M
/Medi		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	Dec.	4c. C	County of Death	7.27 a "
LAGIIII		Longview Nursing				nchester			Carroll	
Funeral Director		210-01-00-10	ex 7. Age □M 2ÅF	(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird Month, Da July	7947	9. Birthp Cour Mar	place (State or Foreign try 12.nd
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
a-f sh	cto	Maryland Carrol	L	Hampste	ad					1 □ Yes 2 No
with the a or 28 be not	Director	10e. Street and Number 408 Dove Lane			10f. Zip Code 2101	74		_	en of What Cour	ntry?
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene. If Health end Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 13.		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - Americ Black, White, Specify: Whi	etc.
in 72 hour n "nature ledical Ex	Completed t	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	nation during most of work d)	ing	16b. Kin	d of Business/Ind	dustry
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wild be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, Last) George Morman	าก			18. Mother's Name Lottie		Maiden S	Surname)	
2 should be end Mental is marked of aumatic ev	٢	19a. Informant's Name/Relationship (7)	ype. Print)			and Number or Run	ral Route Numb			Code)
1 and 2 Health e em 27 is		Doris Landsman - o	daughter	408 D		, Hampste	ad, MD.			0
Page ent c nt: If	1	20a. Method of Disposition 1 □【Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Specify</i>		cemetery, cree Lorraine	natory or other place Park Cem.	Dec. 4,	2009	Bal	ation - City or To	MD.
permit. Pa Dupartmen Important: any Injury		21. Signature of Funeral Service Licens				ss of Facility Ec kl terstown				
Physician // Medical Examiner physician and sthe prival transit sthe prival transit street prival transit street physician and street p	al Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (or as a c.			cerdi culur d	-			Approximate Interval Between Onset and Death Look 25 yrs 5 yr
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome p 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy	/		2:	3d. Date of delive	ery Day Year
v requires that the been signed by should be detact	by	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t		se contribute to t	he cause of death?
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rslcian s certif lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpatier	nt 3 DOA Oth	er: All Nursing He			□Other (Specil	6.1
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injur Wor		28d. Describe			
I or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
Hospita 24 hours Funeral etely filled	edical C	29a. Certifier (Check only one)	ysician: To the best of iner: On the basis of and manner state	examination and/or in	h occurred at the til vestigation, in my	me, date and place, opinion, death occur	, and due to the rred at the time,	cause(s) date and	and manner as s place, and due t	stated. to the cause(s)
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		I Comw. d.	miller	~	725	7443		DEC	c. 1, 20	109
		30. Name and address of person who of Tolm W. Middle	for 688		Print) We	tm ms1	ter, 1	カリ	21157	7
Sta Regist		31. Date filed (Month, Day, Year) DEC 0 1 200	9 3 Registrar	's Signa re	illa)			

Registrar

DHMH 17 Rev 1/2001

Funeral Director 28a-f show and 2 should be filed within 72 hours after death with I lealth and Mental Hygiene. m 27 is marked other than "naturel", or Items 23a or I Baltimore, Maryland 21215-0036 t. Peges 1 and and of the alth and and 27 is

Box 68760. P.O. Division of Vital Records. After death.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 38017 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 113 PM November orey 2009 /Medical give street and humber 4b. City, Town, or Location of Death
Glen Burnie 4c. County of Deat Facility Name (If not institution, Examiner Washington Medical Anne Arundel altimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/01/1930 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 1 F Months Days Hours North Carolina 214-52-7897 79 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 24 No Director Anne Arundel Co Maryland Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7937 Crownsway United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No White Specify 2 Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alex Brinkley Whitford Maude ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James A. Cory / Husband 7937 Crownsway Glen Burnie, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Pinewood Mem. Park Greenville, NC 12/5/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** Shoc days /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, and a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 200 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 🗓 O Certification: To Nanpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours arer To the Funeral Direct 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 68240 of death (Item 23a) (Type, Print) Drive, Glen Burnie, MD 21061 DYK 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 Month Physician/ 30^{Day} 2009 Gregory E. Cox 3:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Golden Living Westminster Carroll If Under 1 Year_ If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 214-80-2679 XXM 2 D F Hours Min 7 1871960 Director MD Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Carroll Westminster 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a Funeral 21158 United States 312 Greengate Ct 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1¾ Never Married 2 ☐ Married ρ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Carroll County ARC Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorsey E Cox Vadonia Payne 19a. Informant's Name/Relationship (Type, Print)
Christine Valdes (sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6305 Oklahoma Rd. Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite 1 K Burial 2 Cremation 3 Removal from State injury or Taylorsville Cem 12/3/2009 Taylorsville, MD 4 Donathon 5 Other (Specify) Name and Address of Facility Prier-Oueen Funeral Home and Crematory 12 W. Old Liberty Rd. Winfield, MD 21784 21. Signatur nter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Par 1. Approximate Interval Between stock, or heart failure. List only one caude on each line Imme iate Cause (Final Onset and Death Pnysician/ se or condition ing in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day 9 Unknown been signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 🔼 No 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 💢 No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 38019 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 535 PM 11 30 Caddick 2009 Grace Irene 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Square Hospital Rosedale Baltimore FRANKLIN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex Date of Birth (Month, Day, Year) 1 ☐ M 2 💢 F 4/3/1925 Maryland 213-20-2010 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Baltimore Middle River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 324 Dark Head Road 21220 S. A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2√ No Specify. Specify. 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Godwin Ida Phillips William Quillin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband Richard Joseph Caddick, Sr. 324 Dark Head Road Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/1 2009 Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, from North ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final

Physician /Medical **Examiner**

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

Funeral

Director

show

or items 23a or 28a-f

-add 10k

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic access

event, the Medical Examinar must be notified

and attending physician for use as the buria

Physician/Medical signed by the a Ş Completed Be 2

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Certification Medical

has

certificate

this

the Hospital or Attending Physiclan:

State Registrar 30. Name and address of person who complete

Damichael 31. Date filed (Month, Day, Year) PIPKin

resulting in death)	a. Ca Ta L 1		N.1 CC		-	
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronar Due to (or as a conseq c. Hypert Due to (or as a conseq	HARTE HUNDER OF SIGN	1	us e		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of 9 Unknown	ancy			23d. Date of delivery Month Day Yea	ır
 Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	cause given in Part I.		o use contribute to the cause of dea 2 No 3 Probably 4 Unk	
				24a. Was an autopsy performed?	24b. Were autopsy findings ava prior to completion of caus death? 1 □ Yes 2 □ No	ilable se of
25. Was case referred to medical			26. Place of De	eath (Check onl one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	OOA Other: 4 In Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)	
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in		
3 Suicide 6 Could not be 4 Homicide determined		ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Numbe tte)	r,
	nysician; To the best of my knimer: On the basis of examinand manner stated.				(s) and manner as stated. and place, and due to the cause(s)	
29b. Signature and title of ortifier	01	2	9c. License number	29d. I	Date signed (Month, Day, Year)	

D54428

FRANKLIN Square DR Balto md 21237

of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 2009

		1	For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of H tificate of L	ealth ai Death	nd Ment		ene 2 0	109	38020
	Physicia		1. Decedent's Name (First, Middle, Last) Janet E. Craw	ford		··		2. Da NO	ate of Death lonth	Day 22	Year 9	3. Time of Death 6:15A M
-	/Medica		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of			4c. County	-	
	Examine	er	Genesis Cromwel			Parkvil					timoı	
	Funeral		5. Social Security Number 6. Sex		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. D	ate of Birth Month, Day, -09-4	Year)	9. Birthpl	ace (State or Foreign try) MD
	Director	-	212-48-3886 Usual Residence of Decedent	60	110.			07	-09-2	+ フ		
	yland now	- 1	10a. State 10b. County	10c. City	, Town or Lo	cation					10	od. Inside City Limits 1 XYes 2 No
	a-fsh	Director	MD NA	Bal	timor				140	g. Citizen of	What Coup	
	vith th	Dire	10e. Street and Number	D1		10f. Zip Code 2120	C		10	U.S		uy:
	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Exactiner must be notified at	Funeral	6203 Eastern	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of H Yes, specify Cuba		in? (Specify)	es or No-	14 Pa	ce - Americ	an Indian,
rd 6	or iten		1 ☐ Never Married ※ ☐XMarried	Armed Forces? 1 ☐ Yes 2 ☑ No		Yes, specify Cuba ☐Yes 2 No	n, Mexican, Specify:	Puerto Ricar	i, etc.)			African
rawfor 215-0036	ral", c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:						6b. Kind of E		rican
аw 15- ("natu	lete	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Deced (Give life. I	lent's Usual Occup kind of work done o OO NOT use retired	ation during most f)	of working	1	OD. KING OF	ousiness/inc	Justi y
Cr. 2121	within iene.	Completed	12th Grade	College (1-4or 5+)		odian						City
	al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)					r's Name (Firs			me)	
∶ E	should be and Mental marked o	To E	Marion F. Wad		r 177	- 1	Mildı			del1		21210
net E. Maryland	2 sho and is ma rauma		19a. Informant's Name/Relationship (7)		19b. Mailir	g Address (Street	and Number	rorRumalRo 11 Do	ute Number,	City or Town	n, State, ∠ıp N2 Ra	ltimore, M
	1 and 2 Health em 27 i	-	LaFran R. Till	ery 20b. F		sition (Name of natory or other place		Date		20c. Location		
nor	Pages nent of unt: If it		1 Burial 2 Cremation 3 □ F 4 Donation 5 □ Other (Specify)	Removal from State	emetery, crer stern	Star C	em .	12-01	-09 E	llico	ott C	Sity, MD
DEC: Ja Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Exactive must be notified at once.		21. Signature of Funeral Service Licens		6	Name and Addre	ss of Facility	Wyli Stre	le Fu eet B	neral altim	Hom nore,	e P.A. MD 21217
			23a. Part 1. Enter the disease, or comp	ications that caused the deat								Approximate Interval Between
	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition	End Stage	Ru	3 100	Dise	use				Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):	1			KINE N	3/01	100	
	Examiner	<u>.</u>	Sequentially list conditions,	b. Due to (or as a conseq		man	IW	mon	m	Disz		
W	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2600	H.	malli.	Ent					
,	executed an and rial-transit	Exal	resulting in death) Last	Due to (or as a consec								
928	cate be executed physician and the burial-transit		(d. Hyre	stone	w						
Box 68760	To the Hospital or Attending Physiclan: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of	aldeath 3	☐ Ectopic pregnand ☐ Other (specify) _	су			1	Date of deliv Month	very Day Year
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æ	The la	mo							perform	ned2 2 No	death? 1 □ Yes	
/ita	siclan: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical examiner?	11 201				of Death (C	heck only on	ne)		
of V	chysia this o	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	nt 3 LI DOA		ursing Home		ence 6 🗆 C		ify)
uo Ou	ding P n. After funer	tion:	27. Manper of Death 1	(Month, Day, Year)	Injury	Wo	rk? ∐Yes 2 🗍		DOGGNEG III	J. 1.1,0.1, 000		
Division of Vital Records,	To the Hospital or Attending Physiclan: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		nome, farm, st	reet, factory, office	e X	28f.	Location (S. City or Town		mber or Rui	ral Route Number,
	Hospita 24 hours Funeral	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at the nvestigation, in my	time, date a opinion, dea	nd place, and ath occurred	due to the dat the time, d	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
3	To the Vithin To the Somple	Me	29b. Signature and title of certifier	/			se number	1 00	2	29d. Date sig	ned (Month	, Day, Year)
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	•		30, Name and address of person who		em 23a) (Type	, Print)	-	inc	4 50	9 T	owe	in, mo
			31. Date filed (Month, Day, Year)	32. Redistrar's Sign	nature 🔺	VY DY	100	7 4/1.	16 20	1 1 3	2 4 - 63 (1.1.
	Sta	ate	TEC 0 4	2000	4	market						

			For State Registrar	State of Maryland / D	epartment of Health and Certificate of Death	Mental Hygien	_ 0 0 7 0 0 0 0 .
	Physici /Medic		1. Decedent's Name (First, Middle, Las.	Geneviev	e Collignon	2. Date of Death Month D	ay 28 2009 4:30 PM
-	Examin		4e. Facility Name (If new institution, give	rook Rd.	4b. City, Town, or Lecation of Dea		c. Couply of Death Baltimore
	Funeral Director		0118-20-100-1	7.1 -14-1	day) If Under 1 Year If Under 24 Hr. Months Days Hours Min		9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign More MD)
	Aaryland f show	ő	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits 1 ☐ Yes 2 No
	with the N a or 28a-	Director	10e, Street and Number	Brook Pd	10f. Zip Code	10g. C	Citizen of What Country?
36	d within 72 hours after death with the Maryland jiene. r then "natural", or itams 23a or 28e-f show the Medical Examitre mast be maffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give A Year or Dates:	13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	n 72	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation 16a. [Decedent's Usual Occupation Give kind of work done during most of wo		Kind of Business/Industry
	othe of the	Be Com	17. Father's Name (First, Middle, Last)	a art	dministrator of 5 and Science (18. Mother's Na	me First, Middle, Maide	hns Hopkins Univ.
Maryland	2 should by and Menta ie markad aumatic ex	은	19a. Informant's Name/Relationship (7	UUND ON 19b.	Mailing Address (Street and Number or	ural Route Number, City	UNKES or Town, State, Zip Code)
	and ealth m 27		DOVID COLLAGO	cometon	Disposition (Name of crematory or other place)	Date 20c.	Contion, MO 31111 Location - City or fown, State
altimore,	parmit. Pages 1 Department of H importent: If itel any injury or ott		1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License	Hemoval from State Hemo	ney volley 1/	12/09 T	Imonium MA
B	20 E E G		23a. Part I. Enter the disease, or comp	lications that caused the death. Do no	16924 YOFK ROOT as cardia	A. MONKT	Approximate Interval Between
1	Physician /Medical		shock, or heert failure. List only of immediate Cause (Final disease or condition resulting in death)	aCa~_Ce 1			Onset and Death
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n of	ding Phy	H- 1	27. Manner of Dalith	1 ☐ Inpatient 2 ☐ ER/Out; 28a. Date of Injury (Month, Day Year) In		Home 5 esidence 28d. Describe how in	6 ☐Other (Specify) jury occurred
Division of	al or Attending s after death. I Director: After id in by the fune	Certification;	Accident investigation Accident investigation	28e. Place of Injury - At home, fare building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street) City or Town, Sta	and Number or Rural Route Number, ste)
	To the Hospital or Attending within 24 hours after death. To tha Funerel Director: After completely filled in by the funer	Medicai Ce		iner: On the basis of examination and	death occurred at the time, date and place for investigation, in my opinion, death occ		
	To the within 2 To tha comple	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
•				completed cause of death (Item 23a) (1	D7870%		11 (30/05)
	C+-	10	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Falls Rd #41T (itheralle.	120'SI23
	Sta Registr	_	DEC 0 1 2009	32. Registrar's Signature	and		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 21 2009 0130 AM **Physician** Stanley A. Conrades Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore -snes HUSPIT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Min. Days 1 X M 2 □ F Vrs Maryland Feb 6, 1926 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic excessions. 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a, State 1 Yes 2 No Funeral Director Raltimore Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 USA 405 Furrow Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No 1944—
If Yes, Give
Year or Dates: 1946 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No white Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) trucker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry A. Conrades Florence J. Roberts ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stanley Conrades Jr./son 15806 Paramount Lane; Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 ☐ Other (Specify) 21. Signature Ronal Srvice Licensee S. Wades Director State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part I. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease are conditions) Approximate Interval Between Onset and Death Së **Physician** disease or condition resulting in death) /Medical Due to (or as a confequence of): Examiner oneumoma Sequentially list conditions, if any, leading to immediate cause. Entire United Sequences (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by the page 2 should be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Sbrillation with 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Thromboses 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2 **1**0 2 100 1 □Yes 1 □Yes Vita director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 Vo 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Jo this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 124 hours after death.
e Funeral Director: After t letely filled in by the funera Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEGNEHI

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38023 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11-26-2009 1837 P^M Linda M. Carlozzi 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) 02-21-1947 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1 □ M 2 🗓 F Austria 62 Yrs 220-56-8223 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ∏Yes 2 X No Harford Bel Air 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 128 W. Ring Factory Rd Apt 142 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George G. Maxfield Martha Atkinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Nash (Daughter) 2936 Airdrie Ave Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11-30-2009 Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. P rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Christia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter this denying Cause (Disease or injury that initiated events resulting in death) Last Myreander Due to (of as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? hyperlipio 24a Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 2 No 1 Tyes 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 ☐ Pending investigation

permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any injury or other traun once. **Physician** /Medical Examiner physician signed by The certificate I of Vital the Hospital or Attending Physician: 127.0 this After Division

Examine as the burial-trai Physician/Medical 9 Completed Be Certification: To funeral nours after death.

neral Director: A
filled in by the fu death. within 24 hours a To the Funeral I Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 🗌 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 ☐ Could not be

me and address of person who completed cause of death (Item 23a) (Type, Print)

Physician

/Medical

Examiner

Funeral

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or 28a-f show

Director

Funeral

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in than "natural", or items 23a or 28a-f sho

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State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

06032299 November 27,2009 M.D-615W. MacPhail Rd. Swite 106 Bel 41, MD 21014

1. Decedent's Name (First, Middle, Last) 2. Date of Dea Month 11-25- Lola N. Cole-Lee 4a. Facility Name (If not institution, give street and number) 2409 Hanson Rd 4b. City, Town, or Location of Death Edgewood Edgewood 5. Social Security Number 2. Social Security Number 2. Social Security Number 2. Date of Death 11-25- Lola N. Cole-Lee 4b. City, Town, or Location of Death Edgewood 5. Social Security Number 2. Date of Death 11-25- Lola N. Cole-Lee 4b. City, Town, or Location of Death Edgewood 1. Days Hours Min. Month Days Hours Min. Month Days Hours Min. 03-22-1											
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	Harford										
Director 260-36-8227 1 □ M 2 □ F 80 Yrs. Months Days Hours Min. 03-22-1	h O Birthelana (State or Foreign										
	9. Birthplace (State or Foreign Country) NC										
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits										
MD Harford Edgewood 10e. Street and Number 10f. Zip Code	1 ☐ Yes 2X No										
106. Street and Number 2409 Hanson Rd 21040	10g. Citizen of What Country? USA										
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	Air, MD 21014										
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IF FEMALE: 23b. Was decedent pregnant 1	23d. Date of delivery Month Day Year										
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24a. Was a support to the control of	prior to completion of cause of										
25. Was case referred to medical examiner? 1											
28d. Describe h	now injury occurred										
28d. Describe h	Street and Number or Rural Route Number, vn, State)										
2 Accident 3 Suicide 4 Homicide 286. Place of Injury - At home, farm, street, factory, office 28f. Location (S City or Tow 29b. Signature and liftle of certifier 29b. Signature and li	cause(s) and manner as stated. date and place, and due to the cause(s)										
29c. License number	29d. Date signed (Month, Day, Year)										
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Tall I fee MD 1946636	1 1 0 1										
30. Name and address of person who completed cause of death filem 23a) (Type, Print) Scott PRESET (03 Bq tq Bird Belcamp	1, 0,										

Baltimore, Maryland 21215-0036

ľ	For State of Maryland		ificate of Dea		, ,	g. No. 2 N	9 38025				
an	1. Decedent's Name (First, Middle, Last) Catherine Luc	ille Co	nokus	2	2. Date of Death Month	Day Yea					
eal er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locat		Novembe	4c. County of De	09				
	516 Holy Cross Road 5. Social Security Number 6. Sex 7. Age (In yrs. I				B. Date of Birth (Month, Day,		Birthplace (State or Foreign				
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		, Town or Loca	tion				10d. Inside City Limits				
ector	Maryland Anne Arundel E		1 ☐ Yes 2X No								
Completed by Funeral Director	10e. Street and Number 516 Holy Cross Road		10f. Zip Code 21225	5	10	g. Citizen of What U.S.A.	Country?				
-une	11. Marital Status 12. Was Decedent Ever in U.s Armed Forces? 1 □ Never Married 2 □ Married 1 □ □ Yes 2 ₹ ▼ No	6. 13. Wa	as Decedent of Hispanio es, specify Cuban, Mex	Origin? (Spec kican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Al Black, Wi	merican Indian, hite, etc.				
by F	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	10	∐Yes 2 X No <i>Spe</i>	cify:		Specify:	White				
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Be	17. Father's Name (First, Middle, Last) Frederick Hein	loin	18. M			aiden Surname)					
은	19a. Informant's Name/Relationship (Type. Print)		Address (Street and No		e Yeager		a. Zin Cada)				
	Susan Nicholas / Daughter		Robinwood R				1and 21225				
			ion (Name of tory or other place)	Da		0c. Location - City					
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		ematory Name and Address of F	12/01			, Maryland				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225										
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	Immediate Cause (Final disease or condition resulting in death)	NE AND	EUOSCE	-ruric	CAND	LOVASU	IAM				
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ted t	BEHEMIA OF GOWEL	•			1 ☐ Ye	s 2 □ No 3 ☑	Probably 4 Unknown				
mple					24a. Was an autopsy	/ prior	autopsy findings available to completion of cause of				
performed? death? 1 Yes 2 Hot 1 Yes 2											
To B	examiner? 1 Yes 2 Mo Hospital: 1 Inpatient 2		Othor			nce 6 Other (S	Specify)				
tion:	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes		Bd. Describe how	w injury occurred					
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Me	29b. Signature and title of certifier	-	29c. License numi	ber		d. Date signed (M					
	- Aller My	00-1/7	D Z177	6	1	JOJEM41	30,2009				
	30. Name and address of person who completed cause of death (Item 7 00/ S- Marvo VER 5 7 . Kg	23a) (Type, Pr	More?	MD	21.	225					
te ar	31. Date filed (Month, Day, Year) 32. Begistrar's Signar	ture	MOREZ								
001	DEC 0 1 2003 Chow	G. HIGH									

DHMH 17 Rev 1/2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State of Maryland / Registrar	•	rtment of H			Reg. No. 2	109	38026
	Physicia		1. Decedent's Name (First, Middle, Last) Laura Co	oley			2. Date of Dea Month Novemb	Day	Year 2009	3. Time of Death 12:45 A.M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) Glen Burnie Health & Rehab.			Location of Death Burnie If Under 24 Hrs.		4c. Count	y of Death	runde1
H	Funeral Director		5. Social Security Number 215 01 0573 6. Sex 1	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Date of O3/O1)	y, _{Year)} 1914	Mar	olace (State or Foreign try) yland
	aryland show	J.	10a. State 10b. County 10c. City, To		urnie				1	0d. Inside City Limits 1 ☐ Yes 2 XNo
	ith the M or 28a-f	Director	10e. Street and Number	Tell D	10f. Zip Code			10g. Citizen of		ntry?
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036	ours affer ral", or ite	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:		□Yes 2█No	Specify:	. ,	Speci	ity: Wh	ite
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. It is marked other than "natural" or items 23a or 28a-f show or other traumatic event, it is the Jich Examination to come the filed at the contract of the filed at the contract of the filed at the filed	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Oth College (1-4or 5+)	necify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Homomoleon						me
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DIVIS	tal or Attenders after death al Director: led in by the	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (City or To	Street and Nun wn, State)	nber or Rura	al Route Number,
1	To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated	n and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place	e, and due t	o the cause(s)
	vithi To th	ğ	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 33). Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Figure 33. Registrar's Signature	10	29c. Licenso	e number D025	19	29d. Date sign	ied (Month,	2009
			30. Name and address of person who completed cause of death (Item 23)	3a) (Type, 1	J TOWE	RS, GI	LEN B	URNI	18, P	D,21061
	Sta Begistr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	d. 4	harked	/	·			1

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar	•	irtment of F tificate of D		and Me	ntal Hyg	giene Reg. No	2009	38	027
	Physicia	n/	1. Decedent's Name (First, Middle, Last)						. Date of Dea	ith		3. Time	
	Medic	al	TRENE HELEN CAN 4a. Facility Name (if not institution, give st			4b. City, Town, or			OVE MBE	$\overline{}$	5, 2009	-	5 P M
ز	Examin	er	Gilchrist Hospi			Towson	Location o	of Death			. County of Death altimore		
	Funeral Director		5. Social Security Number 6. Sex 1 220-20-3230	If Under 1 Year Months Days	If Under Hours		Date of Birti	h (, Year)	9. Birti	hplace (State Intry) Land	or Foreign		
			Usual Residence of Decedent	83									21. 11. 11
	nylanc a-f sho ied at	Director	10a. State 10b. County		ty, Town or Loc	eation						10d. Inside (es 2 No
	the Ma or 28¢		Maryland Harford 10e. Street and Number	I Ab	<u>ingdon</u>	10f. Zip Code				10g. Ci	tizen of What Co		
	s 23a uust b	Funeral	3120 Peverly Run	Road		21009				USA			
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 【XNO If Yes, Give Year or Dates.	l1	Vas Decedent of Hi Yes, specify Cuba	ın, Mexican	n, Puerto Ric			14. Race - Amer Black, White Specify: W		
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Maryland 21215-0036	shoul		19a. Informant's Name/Relationship (Type		1	g Address (Street a							
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3760	ificate ig phy as the		IF FEMALE:							_			
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗌	Ectopic pregnand Other (specify)	Эу			Ì	23d. Date of del Month	ivery Day	Year
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ital	sician: certifii irector	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	l savo i i ii	Othe		ath (Check or	· · · · · · · · · · · · · · · · · · ·		MDu (2)	C: \	christ
of V	g Physer this	te: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun	y at		d. Describe h		Other (Special occurred		<u> </u>
0	tendin eath. or: Aft the fur	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2						
Division of Vital Records,	l or Att after d Direct I in by	Cert	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the building) building at the building of t		eet, factory, office		281	f. Location (S City or Tow		nd Number or Rui i)	ral Route Nun	nber,
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funoral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physic	ian: To the best of my knower: On the basis of examination	/ledge, death o	occured at the time	, date and	place, and c	due to the cau	use(s) a	nd manner as sta	ited.	nanner stated
n	To the Hi within 24 To the Fi complete	Mec	only one) 3 Certifying Nurse	Practioner: To the best of m		leath occurred at th	e time, date		and due to the	e cause(s) and manner as	stated.	name stated.
	5 ₩ 6		29b. Signature and title of certifier	mi		29c. License		d		29d. Da	ite signed (Month	Cay, rear)	
			30. Name and address of person who co			rint)	810	T			11-61		(
			Eric Bush mp		narles	St, Si	it+ 4	105,	balf	ino	re, mD	2120	04-
	Sta Registra		31. Date filed (Month, Day, Year) OFC 0 1 20	32. registrar's Signa	ature.	ares		,			_		

			For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artment of I <i>rtificate of</i>	Health <i>Death</i>	and M	ental Hy	gien Rea. N	^e 2009	38028
			Decedent's Name (First, Middle, Las	t)					T	2. Date of De	ath	ay Year	3. Time of Death
	Physicia /Medic	_	Stephen Bened	ict Conr	eall	Ly			1	Noveml		28,200	9 11:10A ^M
N. A.	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o				40	c. County of Death	-
7			207 Prospect				If Under 1 Year	Bel .		()			ford
	Funeral		5. Social Security Number 6. So	ex 7.Ag S⊈M 2 □ F		ast birthday) Yrs.	Months Days		Min.	8. Date of Bi (Month, D	rth ay, Year	r) 9. Birth Cou	place (State or Foreign ntry)
	Director		085-34-3314 Usual Residence of Decedent		65					June 3	, 19	144 New	York
	/land		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Man a-f st	호	Maryland Harford		Be1	LAir							1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. C	Citizen of What Cou	ntry?
	th wit	<u>a</u>	207 Prospect Mil	l Road			2101				USA	4	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of I	Hispanic C oan, Mexica	rigin? (Spe an, Puerto F	cify Yes or No Rican, etc.)	0-	 14. Race - Ameri Black, White, 	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Eventher must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∰Yes 2 □ I If Yes, Give Year or Dates:	No		1 ⊡Yes 2 No	Specif	y:			Specify:	hito
5-0036	hour tural	ed	15. Decedent's Ed		-	16a. Dece	dent's Usual Occu	pation			16b.	Kind of Business/Ir	hite
15	in 72 n "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5		(Give	kind of work done DO NOT use retire OF Fore	during mo	st of workin	g			,
2121	d with giene er tha	ĕ	Elementary/Secondary (0-12)	5+)+)	Intel	of Forel	Lgn			U.S	Govern	ment
pg	e file at Hy I othe vent,	Be (17. Father's Name (First, Middle, Last)					18. Mot	her's Name	(First, Middle	e, Maide	en <i>Sur</i> name)	
<u> </u>	Ment Ment arked aric e	은	Hubert Arthur Co	nneally I	II			Eli	zabetl	h Marc	ia E	Benedict	
ar	2 sho n and Is mi		19a. Informant's Name/Relationship (7				, , , , , , , , , , , , , , , , , , , ,					or Town, State, Zi	
<u>ح</u> ن	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Exercitival count for rediffical at		Donna S. Conneall	y / Wife	005 0					, Bel .		, Marylan Location - City or To	
ō	ges Int of I		20a. Method of Disposition 1 Note: Burial 2 □ Cremation 3 □	Removal from State	20b. P	emetery, crei	osition (Name of matory or other pla	ice)	D	ale	200.1	Location - City of 1	JWII, State
Baltimore, Maryland	it. Pa irtmei irtant injury		4 Donation 5 Other (Specify		Be]		Memorial					L Air, Ma	ryland
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licen	Much			2. Name and Addr CCOMAS FU					n, Maryla	nd 21009
			23a. Part 1. Enter the disease, or comp	olications that caused	the death	n. Do not en	ter the mode of dy	ing, such a	as cardiac o	r respiratory	arrest,	1, MOLYIA	Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final	one cause on each II		2 11 0	ATUS	-					Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as			210 111	4					of enes
	Examiner		Sequentially list conditions	b									
11/	pi ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):							
K	and and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consedi	ience of):							
8760,	icate be executed physician and s the burial-transit	alE		4									
687		edical		(d									
Вох	eath certif attending for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75.					23d. Date of deliv	very
	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			□ Ectopic pregnan □ Other <i>(specify)</i> ₋	cy				Month	Day Year
P.O.	at the by the	Physician/M	9 Unknown										
	Attending Physician: The law requires that the death certifoleath continued to death carding acroes. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	<u>중</u>	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the u	nderlying cause gi	ven in Par	t I.				the cause of death?
oro	requii	ted									res	2 NO 3 PIC	
ဒ္ဓင	e law has b	Completed								24a. Was	s an opsy ormed?	prior to c	opsy findings available ompletion of cause of
a F	r: The icate r, pag									1 □Yes		√o 1 ☐ Yes	2 🗆 No
<u>Ş</u>	siciar certii recto	Be	25. Was case referred to medical examiner?	Hospital:			D.a. Ot	her:		(Check only		- 5-4	
of	Phy er this eral di	1	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		28b. Time o	nt 3 L DOA	4 🗆 1		ne by Hes 28d. Describe		6 ☐Other (Speci jury occurred	ity)
ion	nding th. :: Afte e fune	ţi	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		y, Year)	Injury		ork? ⊒Yes 2[□No				
Division of Vital Records,	Attencer death rector: by the I	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At ho	ome, farm, st	reet, factory, office		2	28f. Location City or To	(Street a	and Number or Ru	ral Route Number,
Ö	ral or rs afte ral Dir led in	Certification: To		Dailding, Co	o. (opcon	,,				0.1,7 0.1 7.0			
U	To the Hospital or Attending Physician: The law requires that the de within 24 burous after death. The Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	f examina	wledge, deat ition and/or in	th occurred at the to nvestigation, in my	time, date opinion, d	and place, a eath occurr	and due to th ed at the time	e cause e, date a	e(s) and manner as and place, and due	stated. to the cause(s)
011	Fo the within Fo the somple	Me	29b Signature and title of certifier	1/1	D. h	+1	29c. Licen	ise numbe	r		29d. E	Date signed (Month	, Day, Year)
			Mart A Dan	e AA	- D	SNC	M, BI	12	9135	55	1	1-30-	2009
			30. Name and address of person who	~ 1	leath (Item	23a) (Type,	Print)	7 1		1.0	-	. !	*
				MCDI	A	Kd	1500	7 Y	R	NW	'21	1014	
	Sta Registr		31. Date filed (Month, Day, Year)	9 Registi	ar's Signa	T. pa	Mal						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ALICE /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Country) Months 1 □ M **XIX**F Jan. 25, 1932 Pennsylvania 177-24-3460 77 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Wedical Evantiner must be notified at 1 ☐ Yes XXNo Owings Mills Funeral Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hyglene.
Int: If item 27 is marked other than "natural", or Items 23a or 2 U.S.A. 130 Cedarmere Rd. 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify. Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Maryland Cup Corp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Potts J. Fred Burhenn, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 130 Cedarmere Rd. Owings Mills, MD 21117 Charles C. Decker / Husband Department of Health Important: If item 27 any injury or other ti Date 20c. Location - City or Town, State 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/5/2009 Greensburg, PA St. Clair Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature Fineral Service Lie 11605 Reisterstown Rd. Owings Mills, MD21117 muru 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Box 68760, physician Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 HInknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 2 No 1 ☐Yes ospital or Attending Physician: hours after death. 25. Was case referred to medical 26. Place of Death (Check only one)

Other: 4 □ Nursing Home 5 □ Residence □ Lother (Specify) director, Be examiner' 1∐ Yes 2 And 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Feath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Funeral Director: Aft 1 □Yes 2 □No investigation 2/ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State DEC 0 1 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:15 AM **Physician** 2009 Dierra Jay'Lynn Dowery November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10-28-2009 5. Social Security Number /a Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** 1 🗆 M 2 🔀 Days MD Director 29 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 1 ¥ Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zin-Code USA 2819 Jefferson Street 21205 Funeral death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status filed within 72 hours after 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: Black à 3 Widowed 4 Divorced "natural", Hygiene. other than "nature ent, the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working n/a life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) / a Elementary/Secondary (0-12) n/a marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event. Be Durant C. Dowery Cierra Harper ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2819 Jefferson Street Balto, MD 21205 Cierra Harper -Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-2-2009 Baltimore, MD Greenmount ! 21. Signature of Funeral Service Licensee March East F/H Dlad Wane 1101 E. North Avenue BALTO, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final extreme **Physician** prematuritu disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** encephalopath POXIC 15ch
(or as a consequence of) Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dyl attending physician and I for use as the burial-transit be executed Due to (or as a consequence of) resulting in death) Last Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy Year Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed The ! 2 🗋 No 2 🗌 No 1 Yes Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No Hospital: 1 Thpatient 3 🗌 DOA 2 - ER/Outpatient 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 1 Natural funeral Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: I or Attending F after death. After 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 🗌 No I Director; Af 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier (check only 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P.O. of Vital Records, Division Hospital 24 hours To the within 2

> Amit 31. Date filed (Month. State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agrawa gistrar's Signature we

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

November 26 2009

29c. License number

RES 000

TPAVES EORGIA

> Box 68760 P.O. Records, Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician/ 00:48AM reorgia avis 2009 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deatl Examiner GOOD SAMARITAN HOSPITAL NI BALTIMORE MD 8. Date of Birth (Month, Day, Yer If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛂 213-32-190= Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Nes 2 No Honore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21239 vdon/ea 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural and injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 1905 Idun Way SON ea altimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State altimore 4 Donation 5 Other (Specify) 21. Sime ur Funeral Service Lie MD ZIZOT 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ EPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PHELMONI Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🕅 No Month Year Pregnant at time of death signed by the at Id be detached for 4 ☐ Pregnant 9 ☐ Unknown 1 L Yes 2 P 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION, HYPERLIPIDEMIA, DIABETES 2 ☐ No 3 X Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of CONGESTIVE HEART FAILURE this certificate has ral director, page 2 autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Tes 2 X No 1 A Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After thileted filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Satish Kabra MD **RES** 000 HOV 24,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 5601, LOCH RAVEN BLVD, BALTIMORE, MD. 21239 SATISH KABRA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 26, 2009 **Physician** Margaret M. Das /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Parkville 21 Skywood Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 4, 1922 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2**X** F India Director 217-64-1463 87 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be notified at 10a. State 1 ☐ Yes 2 The No Parkville Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 21 Skywood Court Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify. If Yes Give Specify: Indian 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Rafiq Allah Rakhee ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21 Skywood Court-Parkville, Maryland 21234 Nirmala Lall-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Belair, Maryland Nov. 30, 2009 Gardens

22. Name and Address of Facility
Evans Funeral Chapel and Cremation Service
8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician erebrovascy Year disease or condition resulting in death) /Medicai Due to (or as a consequence of): **Examiner** erosc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and the burial-trar Due to (or as a consequence of) physician Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 \(\subseteq \text{ Ectopic pregnancy} \) in the past 12 months? Month Year Day 5 ☐ Other (specify) the detached 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1∏Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 ☐ Yes 2 No director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1□ Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, Physician:

Maryland 21215-0036

Baltimore,

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral or Attending Hospital the

State Registrar

NAEEM 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Medical

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 200 /Medical City, Town, or Location of Death County of Death 4a. Facility Name (If not institution give street and no Examiner odical orani-July + Luc 8. Date of Birth (Month, Day If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days June & 213-62-7002 1 □ M 22 N Director 110 mar Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28e-f show other traumatic event, the Modical Examiner must be notified at 1 Nes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ģ Specify: 3 ☐ Widowed 4 ☑ Divorced "naturef" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or,5+) Elementary/Secondary (0-12) Domes mestic NA 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kicha ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip (2de) -1 G1 item 27 i andallsTu lamika 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it eny Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-0 4 Domation 5 Dother (Specify) aure of Funeral Service Scensee 3405 -m. Walla nen Pint 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a contenue of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Box 68760, or Attending Physicien: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy After this certificate hes been signed by the atte funeral director, page 2 should be detached for Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No P.0. 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 24 | 106 Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after dean al Director; Aftr 1 ☐ Yes 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 30

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		1- For State Certificate o	f Death	Reg. N	No.				
Physicia		Decedent's Name (First, Middle,Last)	ame (First, Middle,Last) 2. Date of Death						
ledical Exami	ner	Purnell Drake							
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
		Sinai Hospital	Baltimore		N/A				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min.	. 8. Date of Birth(N	MM/DD/YYYY) 9. Birti Foreigi	n			
Director		$214-78-4185$ $1 \times 2 = 51$ Yr		8/16/1		intry) MD.			
	t	Usual Residence of Decedent							
' any		10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits			
nd show	5	Md. N/A Baltimo	re			1X Yes 2 No			
Aaryland 28a-f show Lat once.	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?			
th the Maryland 23a or 28a-f sho notified at once.	吉	3809 Roland View Avenue	21215		USA				
with ns 23 be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Sp			can Indian, Black,			
death r iter	Ĕ	1 Never Married 2 Married Armed Forces? If Yes 2 X No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.				
after	P, F	3 Widowed 4 X Divorced If Yes, Give Yeer or Dates:	Yes 2 X No specify:		Specify: B	lack			
ours		15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of vectors) and of working life. DO NOT use reti		b. Kind of Business/I	ndustry			
6 .72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Ç	, i					
5-0036 iled within 72 Hygiene. I other than '	티		t Metal Mechan			Industry			
5-C iled v Hygi		17. Father's Name (First, Middle, Last)		e (First, Middle, Maio					
2121 ould be fi Mental marked c event,	Be	Thomas Drake	Flos	sie Atl	<u>ee Miste</u>	r			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	۱٩	N	ng Address (Street and Number or F						
MD nd 2 sho alth and m 27 is		Denise England 3809 20a. Method of Disposition 20b. Place of Dispo	Roland View A	venue, B	altimore	Town State			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		1 V Burial 2 Cremation 3 Removal from State crematory or c	other place)						
Page Page ment tant;		4 Donation 5 Other Specify:// Woodlaw	n Cemetery 11/	28/2009	Gwynn O	ak, Md.			
Balt Sermit. Separti Import	- [21. Siv and of Funeral Service Li × n × e	Name and Address of Facility Estep Brothers 300 Eutaw Place	Funera	1 Servic	e, PA			
E.E.O.E.		Cur 11910 11	300 Eutaw Plac	<u>e,Balti</u>	<u>more, Md</u>	. 21217			
Physician /Medical		23a. Part. Enter the disease, or complication, that caused the death. Do not enter fair re. List only one cause on each line.			shock, or heart	Approximate Interval Between Onset and			
⊂xaminer	- 1	Immediate Cause (Final disease a Narcotic (heroin) and	d alcohol intoxi	cation		Death			
<i>}</i>		or condition resulting in death) Due to (or as a consequence of):							
	ᆈ	Sequentially list conditions, if any, leading to immediate b. / Due to (or as a consequence of):							
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated							
g t	Examiner	events resulting in death) Last Due to (or as a consequence of):							
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760, icate be physici the buri		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery				
eath certif	sician	past 12 months:	Fetal death 3 Ectopic pregnation Other (Specify)	ancy	Month [Day Year			
Box 68 death certif the attending ed for use as	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)						
that the de ned by the detached f	Phys	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?			
res that	ģ			1 Yes	2 No 3 Prot	oably 4 🗸 Unknown			
ds, equir	ě			24a. Was an		itopsy findings available			
COF law r has b	힐			autopsy performe	ed? death?	completion of cause of			
tal Records, cian: The law require certificate has been sector, page 2 should be	Completed			1 ✔ Yes 2	No 1 Y	es 2 No			
Division of Vital Rectator Artending Physician: The rs after death. al Director: After this certificate led in by the funeral director, page	Ba	25. Was case referred to medical examiner? Hospital: Inspirate 2 FR/Outpatie	26.Place of Death (Check		esidence 6 Othe				
f Vi	٩	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of	III 3 DOA 4 INDISI	ng Home 5 Re		1.			
n of ding Pt h. After	ë	1 Natural (Month, Day, Year)	A No. of X No.	unk	Tillary occurred				
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Jivi al or 2 safter 1 Dire	Certification:	3 Suicide 6 X Could not be determined (Scecify) residence	eet, ractory, office building, etc.	or Town, Stat	e) 2630 050	ego Ave			
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 24 hours after death. Funeral Director: After this certificate has been signed by the attending rely filled in by the funeral director, page 2 should be detached for use as		4 Homicide		Baltimor	_				
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	293. Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner:On the basis of examination and/or investig	curred at the time, date and place, and gation, in my opinion, death occurred	u due to the cause(s at the time, date an	s) and manner as stat d place, and due to th	ne cause(s)			
To the within? To the comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		9d. Date signed (Mo	 			
1041		(a) 1111A	O.C.M.E.		November 21, 2				
wa			0.0						
V	ļ	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 21	1201		0			
·	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,						
Regist		DEC 0 1 2009 June S. Sono							
					OCME				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38035 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** $\boldsymbol{A}^{\mathsf{M}}$ Judith L. Davis November 27 2009 5:51 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day,) Jan. 12, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🙀 F 212-52-0945 51 Jan. 1958 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglen are. Internated the Titler at I marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nuttled at 1 ☐Yes 2 ☐ No Director MD Baltimore Lutherville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11 Croftley Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📈 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No þ Yes Give white 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Hammond Madaline Truitt ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Davis husband 11 Croftley Road; Lutherville, MD 21093 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation Dother (Specify) Dulaney Valley Mem Gardens 12/5/09 Timonium, MD Other (Specify) n ray Ser 22. Name and Address of Facility 21. Signature of 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ntestinal hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending pl IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 pionths? 1 ☐ Yes 2 2 No Month 5 Other (specify) certificate has been signed by the rector, page 2 should be detached it 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed 2 🗆 No ¥es 2 □ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my entires. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

6701

Towson, MD

21204

of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Phyllis Lorraine Doonan 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD GELAIR HEALTH ANDREHABILITARN LENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🔀 F 215-32-5552 Director 1932 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examinar must by notified at XXYes 2 □ No Directo Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 E. BelAir Avenue 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: white Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 housewife in home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Thomas Edward Brewer Lena Mae Salver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ed Doonan 300 Stone Run Dr., Rising Sun, MD 21911 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Angel Hill Cemetery 11/25/2009 Havre de Grace, MD 21. Signature 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 Aberdeen, sand 23a. Part 1. Enter the disease, or complications that, aused the death. Do not enter the mode of dv/g, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of a ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wales /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran and Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknow signed by t ontributing to death but not resulting/in the underlying cause given in Part I. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate I 1 □ Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending 1 Natural 2 □ Accident 5 ☐ Pending investigation within 24 hours are.

To the Funeral Director: Af hours after death. 1 ☐ Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only one)

e

29b. Signature and title of certifie

Year,

DEC 0 1 2009

DHMH 17 Rev 1/2001

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

308BUSIZESE

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible

			For			aryland / Dep					•		
			1 - State Registrar			Ce	rtificate of	Death		Reg. N	.2009	3803	
ı	Physici: /Medic		Decedent's Name (First, Middle Aaron Lee Da					14	Mon	of Death	ay Year 2009	3. Time of Death 12:01a M	
1	Examin		4a. Facility Name (If not institution	-	number)		4b. City, Town,	or Location of I	Death	4	c. County of Death	1	
1			Harford Memoria					de Gra			Harford		
ı	Funeral Director		5. Social Security Number 220–42–8584	6. Sex 1 3 M 2 ☐ F		e (In yrs. last birthday, 65 Yrs.	Months Days		Min. Augu	of Birth nth, Day, Year 12,	1944 Ma	nplace (State or Foreign Intry) ryland	
	and		Usual Residence of Decedent 10a. State 10b. County			10c. City, Town or Lo	ocation					10d. Inside City Limits	
	Maryl	tor	Manual Ha	rford			rdeen					1⊠Yes 2 □ No	
	r 28a	Director	Maryland Ha 10e. Street and Number	IIOIG		, noc	10f. Zip Code			10g. C	itizen of What Cou	untry?	
	h with		403 Ford Stre	et				21001			USA		
	ems	Funeral	11. Marital Status	12. Was D	ecedent Forces?	Ever in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin	n? (Specify Yes	pecify Yes or No-		ican Indian,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Modical Eventiner must be notified a	δ	1 □ Never Married 2 ★ Marr 3 □ Widowed 4 □ Divorced	ried 1 TYe If Yes,	s 2 Give r Dates:	No	1 □Yes 2 XXNo		r donto rilodii, o	,	Black, White, Specify: Wh	White	
2-0	72 hc	etec	15. Deceden (Specify only highe	nt's Education	d)	(Give	edent's Usual Occupation a kind of work done during most of working			16b.	Kind of Business/li	ndustry	
121	filed within 72 Hygiene. other than "na' ent, the Medic	Completed	Elementary/Secondary (0-12)	College	(1-4or	life	DO NOT use retir	, and the second	-		~		
d 2	filed v Hygid ther	ပိ	17. Father's Name (First, Middle,	Last)	0		laborer		Middle, Maide	ate of Ma	ryland		
an	2 should be f h and Mental I r Is marked of raumatic eve	To Be	Ellwood Day	,			Oneida Arnold						
ary	s 1 and 2 should of Health and Men Item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number)								per, City or Town, State, Zip Code)		
	and 2 ealth an 27 le		Clara E. Day (wife)		403	Ford Str	eet, Ab	erdeen,	, MD 21	001		
ore	les 1 of He if Iten or oth		20a. Method of Disposition	3 Removal fro	ım Stata	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c.	Location - City or T	own, State	
<u>=</u>	t. Pages tment of tant: If It		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)		R.A. Ferr			/24/200	09 Wes	st Cheste	er, PA	
Baltimore,	permit. Pages Department of Important: If It any Injury or once.		21. Signature of Funeral Service	Licensee	MO	7/ - 1/2 - 1	2. Name and Add berdeen ,		Tarring	g_Cargo	Funeral	Home, P.A	
			23a. Part 1. Enter the disease, or	complications the	at cau	the death. Do not en					,,,	Approximate Interval Between	
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause o		PS1S						Onset and Death	
	/Medical		resulting in death)	Due Due	a consequence of):								
	Examiner	Sequentially list conditions, b.											
	ted isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due	to (or as	a consequence of):	of):						
	ficate be executed physiclan and s the burial-transit	Examiner	that initiated events resulting in death) Last	c	to (or as	a consequence of):	of):						
760,	te be o	calE											
9	rtificat ng phy as th					- 71.	-						
Вох	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant			of pregnancy 2 Fetal death 3	☐ Ectopic pregnar	ncv			23d. Date of deli	,	
0.	at the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ P			Other (specify)				Month	Day Year	
<u>.</u>	The law requires that the site has been signed by the hage 2 should be detached.	Phy	Part II. Other significant condition	ons contributing to	death h	out not resulting in the I	inderlying cause o	iven in Part I	236	e. Did tobacco	use contribute to	the cause of death?	
ecords,	uires that signed I d be det	Completed by		ICER			maon, mg oaddo g				2		
S	w requir been s should	lete	T-CELL	LYMF	Ho	MA			246	a. Was an		topsy findings available	
Æ	: The law cate has page 2 (duc	7	0/10(1	170	,000			_	autopsy performed?	prior to death?	ompletion of cause of	
			25. Was case referred to medical	1				26 Place o	1 □ of Death (Check	Yes 2 M	lo 1 □Yes	2 12 No	
	di is	To Be	examiner? 1 Yes 2 No	11 - 11 - 1	Inpati	ent 2 ☐ ER/Outpatie	nt 3 □ DOA O	ther:			6 ☐ Other (Spec	cify)	
n ot	ding Ph h. After th funeral	L:uc	27. Manner of Death 1 Natural 5 □ Pendin		ate of Inje	ury 28b. Time (scribe how inj		,	
<u>S</u>	tendi eath. or: A the fu	cati	2 ☐ Accident investig	gation				⊒Yes 2 □ No	0				
Division	or At after d Direct in by	Certification:	3 Suicide 6 Could i 4 Homicide determ	ined 200. Pl	ace of In ilding, e	ury - At home, farm, st c. (Specify)	reet, factory, office	y, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	ie Hospital or Attending P n 24 hours after death. Ie Funeral Director: After toletely filled in by the funera									stated			
	e Hos n 24 h e Fun letely	edical	(Check only 2 Medical one)	Examiner: On the	e basis of	of examination and/or i	nvestigation, in my	opinion, death	n occurred at the	e time, date a	nd place, and due	to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifie				29c. Licer	nse number	-/	29d. E	ate signed (Month	n, Day, Year)	

31. Date filed (Month, Day, Year)

DEC 0 1 2009

State Registrar

bass /62/11

			Please							Are Legible		
		For		State of M	arylan			Health and N	/lental Hy			
		1 - State Registrar				Cei	rtificate of	Death		Reg. No.2 () ()	38038	
Physici	an	1. Decedent's Name Shirle					El abda		2. Date of De	eath er 25, 200	3. Time of Death	
/Medic	al			Ann			Elchin		Novemb			
Examin	er			ive street and number) a bilitatio n		ar	Glen B	or Location of Death		4c. County of De		
Funeral	_	5. Social Security Nu				ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bit	rth 9. B	irthplace (State or Foreign	
Director		218-36-393	34	1□M 💥 F	68	Yrs.	Months Days	Hours Min.	Feb 24	, 1941 Ma	Country) ryland	
p ,		Usual Residence of	Decedent		10- 0'5	, Town or Lo					10d. Inside City Limits	
arylan show	ō	10a. State	10b. County								1 □Yes ½X No	
ith the Ma or 28a-f	Director	MD 10e. Street and Num	Anne Ar	undel	Gle	n Burn	10f. Zip Code			10g. Citizen of What (
with Ba or				1							Journal y .	
42 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exprinent.	Funeral	1812 Norf	olk koa	12. Was Decedent	Ever in U.S	3. 13.	21061 Was Decedent of	Hispanic Origin? (Sp ean, Mexican, Puerto	ecify Yes or No	USA 14. Race - Ar	nerican Indian,	
or ite		1 Never Marrie	ed 2 Married	Armed Forces? 1 □Yes 🏋	No				Rican, etc.)			
ral",	d by	My Widowed	4 Divorced	If Yes, Give Year or Dates:			1 □Yes 🏋 No	Specify:		Specify: W	hite	
72 h	Completed	(Speci	15. Decedent's lify only highest g	Education rade completed)		(Give	dent's Usual Occu kind of work done	during most of work	ing	16b. Kind of Busines	s/Industry	
within ene. than	ш	Elementary/Secon	ndary (0-12)	College (1-4or	5+)		DO NOT use retire	ra)		Own Ho		
filed Hygin		12 17. Father's Name (i	First, Middle, Las	st)		поп	e Maker	18. Mother's Nam	e (First, Middle	ii.e		
d be ental ked o	To Be	Elmer Cla		•				Anna Ber				
2 should be filed withing and Mental Hygiene. Is marked other than raumatic event, the Mental Hygiene.	1	19a. Informant's Na		(Type. Print)		19b. Mailin	ng Address (Street			per, City or Town, State	, Zip Code)	
		Mr. Rober	t J. E1	chin, Jr.	/ Son	260	8th Stre	et Pasad	ena, MD	21122		
permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other once.		20a. Method of Disp	osition		20h P	ace of Disno	sition (Name of natory or other pla		Date	20c. Location - City of	or Town, State	
Pages ment of ant: If it		1)⊈Burial 2 ∟ 4 ☐ Donation	1 Cremation 3 I 5 ☐ Other (Spec	Removal from State			n Mem. P	; nec_		Glen Burn	ie. MD	
eparti eparti porti ny Inj		21. Signature of Fur	neral Service Lic	ensee	- 111-	22	. Name and Addre	ess of Facility Sin	gleton	Funeral an	d Cremation	
1 80 E # 8			mol	MUUKM	014	19 s	ervices,	PA 1 2nd	Ave SW	Glen Burn	ie, MD 21061	
		shock, or hear	t failure. List onl	mplications that caused y one cause on each li	d the death ne.	. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death	
Physician		Immediate Cause (I disease or condition resulting in death)	Final 1	a. KESP/	121576	ppy	FAILL	PG			Onset and Death	
/Medical Examiner		resulting in death)	•	Due to (or as	10: 11	encu of):	PNIDAK	WIT	4 BA	CAIN/ mi	TACTACIC	
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): Due to (or as a consequence of):										
uted d tnsit	Examiner	cause. Enter Underlying Cause (Disease or injury Cause (Disease or injury										
be executed sician and burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a const quence of):										
ate be nysicia ne bur	ical	CONGUSTIVE HEARY FAICHNE										
The law requires that the death certificate bate has been signed by the attending physic bage 2 should be detached for use as the bu	Physician/Medical	IF FEMALE:					W-0					
ath ce ttendi or use	an/I	23b. Was decedent in the past 12 g		23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3 [Ectopic pregnan	cy NA		23d. Date of o		
the a	sici	1 ☐ Yes 2 🔏	No	4 □ Pregnant a 9 □ Unknown	at time of d	eath 5	Other (specify) _			Month	Day Year	
w requires that the d			cant conditions	contributing to death b	out not resu	lting in the ur	nderlying cause di	ven in Part I	23e. Did	tobacco use contribute	to the cause of death?	
signe d be	d b	H	1 PER	TENSIO	N		tacily in global or gr		1 🗆		Probably 4 ☐ Unknown	
v requ	Completed	4/	11POK	AIFANI	A	- 01	THUN	CATION	24a, Was		autopay findings available	
The lav cate has page 2:	ш		9/0/8	100 100/1	/		11/10	21/10/	auto	psy prior to death	autopsy findings available o completion of cause of ?	
ician: Th certificate ector, pag		25. Was case referre	ed to medical	1				00 Pl f D	1 □ Yes	2.2 √0 1 □ Y	es 2 No	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, I	o Be	examiner?		Hospital: 1 Innatio	ent 2∏ I	ER/Outpatien	t 3 DOA Ott	26. Place of Deat		idence 6 ☐Other (Si	naciful	
g Phy ter thi	n: To	27. Manner of Death		28a. Date of Inju (Month, Da		28b. Time of				how injury occurred	Jeony)	
ath.	Certification:	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	on	iy, rear)	пушу		Yes 2 No				
r Atte	tific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	be 28e. Place of Inj building, et	ury - At ho	me, farm, stre	eet, factory, office			Street and Number or wn, State)	Rural Route Number,	
rrs aff	Ce											
Hosp 4 hou Fune tely fii	edical	(Check only	1 D Certifying F 2 Medical Exa	miner: On the basis o	of examinat	vledge, death ion and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occur	and due to the red at the time	e cause(s) and manner , date and place, and d	as stated. ue to the cause(s)	
the the mple	Med	one)	God committee	and manner st	ated.		700 Linon	no numbor		29d. Date signed (Mo	oth Day Year)	
5.≥5 8	_	29b. Signature and	Coll	afast		,e2	29c. Licen	D18474		NOV ENII		
	•	OF PLE	5/1.6	TALING	HU	5 81	Print)	10/00		100 Great	ere a la la	
10				completed cause of cause of cause			,	Maryand ?	1061			
Sta	te	31. Date filed (Month	h, Day, Year)	2. Registr	ar's Signat	uro		marjanu Z.				
Registr		QE	C 0 1 20	09 Cerdina	1 19.	fran	Rad					
				E		7.7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009

38039

		_ 1	State Registrar	Certificate of L	Death		Reg. No.			
	Dhysisis	2/	1. Decedent's Name (First, Middle, Last)			2. Date of De Month		Year	3. Time of De	
	Physicia: Medic	al .	David T. Eminizer			Novemb		2009	11 am	М
(Examin	J	4a. Facility Name (if not institution, give street and number) 4133 Crest Heights Road	4b. City, Town, or Baltime	r Location of Death			ity of Death		
	Funeral		5 Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	g. Birth	place (State or F	oreign
	Director		215643892 1 m 2 0 F 53 52	Yrs. Months Days	Hours Min.	(Month Da	150	Mar	yland	
	D MO	_ [Usual Residence of Decedent	Town or Location					10d. Inside City I	Limits
	ırylanı a-f sh fied a	cto	Anne Arundel	Brooklyn Park					1 🗆 Yes 2	No
:	or 28g	를 -	10e. Street and Number	10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
	with the 23a can be ust be	Funeral Director	515 Taney Avenue	21	.225		U.S	.A.		
	death items ner m	ᇤ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?/	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)		ace - Americ		
20	after (Il", or xamir	d by	1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes, Give Year or Dates.	1 🗆 Yes 2 🖼 No	Specify:		Specify: White			
Ş	hours natura ical E	Completed	15. Decedent's Education	16a. Decedent's Usual Occup	oation		16b. Kind of Business Industry			
מנק ב	in 72 e. nan "r	d u o	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kind of work done life, DO NOT use retired)) -	ng	First	. Mortga	906	
7	d with hygien ther ti	Be C	1Z 3	Mortgage Bro	18. Mother's Nam	e (First Middle	L			
anc	oe file antal F ced o' c evel	TO E	Thomas H. Eminizer		Norma	e (i iisi, iviidaio,	S. Schr		y	
ar Z	is and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. of Heath and Mental Hygiene. If the marked other than "natural", or items 29a or 28a-f show frother than "natural", or items 29a or 28a-f show frother traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street					Code)	
Ĕ	id 2 sh ealth a n 27 it er trai		Norma S. Eminizer (Mother)	515 Taney Aven	nue, Baltimo	re, Mary				
Baltimore, Maryland 21215-0036	e 1 ar t of He lfiter or oth		20a. Method of Disposition 20b. Plant 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Central Plant State	ace of Disposition (Name of metery, crematory or other plan or Hill Cenetery	12-3-	Date OO	20c. Locatio	•	own, State Maryland	Ì
Ē	it. Pag rtmen rtant: njury		4 Donation 5 Differ (Specify)							\neg
Ba	permit. Page 1 a Department of I Important: If its any injury or of		21. Signature of Funeral Service Licenson	iryland	ome P.A. 21225					
		Н	23a. Part . Enter the disease, or complications that caused the death. spock, or heart failure. List only one cause on each line.	. Do not enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	en
F	nysicia	1			Onset and De	ath				
	Medical Examiner		disease or condition resulting in death) a. Due to (or is a consequence)							
	Lxammer	ē	Sequentially list conditions, if any, leading to immediate b. Due to of as a consequel	1 stell	-					
	ed nsit	Examiner	cause. Enter Underlying Cause (Disease or linjury	y Vascola	e condrovousuley els					
X	execut in and ial-tra		that initiated events resulting in death) Last C. Due to (or as a conseque	ance of):						
ွဲ	tificate be executed ng physician and as the burlal-transit	Medical	d					_		
68760	iji Dige		IF FEMALE: 23c. If yes, outcome of pregnance	ncv	-		004	Date of deli		
Box	ath ce attenc for us	Physician/	in the past 12 months?	death 3 Ectopic pregnan	ncy			Date of deli Month	Day Ye	ar
W.	he de y the sched	hysi	1 Yes 2 No 9 Unknown							
P.0	requires that the death cert been signed by the attendir should be detached for use	by P	Part II. Other significant conditions contributing to death but not resul	Iting in the underlying cause g	jiven in Part I.				the cause of dea	/
ds,	equires sen sig ould b	ted							obably 4 🖫 🛈	
COL	law re has be e 2 sh	Completed				ner	opsy ormed?	prior to c death?	opsy findings av ompletion of cau	use of
æ	r: The ficate r, pag		25. Was case referred to medical	26.1	Place of Death (Chec	1 Tes	2 No	1 □ Yes F • ds	2 LYNo S Home	
/ita	rsicial s certi directo	To Be	examiner?		her:		idence 6 🖭	/		
of	ng Phy ter this neral c			28b. Time of 28c. Injury wor	ırv at		how injury occ			
ion	tendir leath. tor: Af the fu	ifica	2 Accident Investigation	M 1 [Yes 2 No	001 1	(Ot	mhar ar Bur	al Pouto Numbo	
Division of Vital Records, P.O.	I or Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2:	Certificate:	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	me, farm, street, factory, office			(Street and Nu wn, State)	mber or Hur	al Route Numbe	τ,
Ω	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending the Funeral director, page 2 should be detached for use completed filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death occured at the tim	ne, date and place, a	nd due to the o	ause(s) and ma	anner as sta	ted.	ner stated
	To the Hospital within 24 hours To the Funeral completed filled	Med	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	knowledge, death occurred at t	the time, date and pla	ice, and due to	he cause(s) and	manner as	stated.	ner stated.
V	Voit To 1		29b. Signature and title of certifier T. Penn M	29c. Licen), 99 ZS		29d. Date sig	ned (Month	Day, Year)	
			30. Name and address of pareon who consolided gause of death (Itam (100	2		
			30. Name and address of person who completed cause of death (Item 2)	Suik 300 P.	ihesville 1	MD 21	208			
ŀ	Sta Registr		31. Date filed (Month, Day, Year) 2009 32. Refistrar's Signatu	de facts						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2009 07:10 PM 11 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSP! tou Samaritan Good TECHLIMETE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Paytimore, mo 1 □ M 2**X** F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ms 23a or 28a-f show 1 Yes 2 □ No Director mor 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 5, H by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any Injury or other traumatic event, The Madical Evantina. Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify. Specify: Whit 3 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or fown, State Methed of Disposition Date 1 Burial 2 Cremation 3 Removal from State 109 Timonium, mu 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Chapelmo 21234 8800 Hartord Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A PNEUMONIA TERAL Physician Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Tillnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Effusision DIEURU 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed lellitus Diobetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Inpatient 2☐ER/Outpatient 3☐DOA ical Certification: To

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760,

with the Maryland

death

21215-0036

Baltimore, Maryland

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records,

the

1 | Yes 2 | 140 27. Manner of Death

5 ☐ Pending investigation 6 □Could not be determined

28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Natural

2 Accident 3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

23986

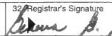
29d. Date signed (Month, Day, Year) 11-27-2009

MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samandan Hospital, 5601 Lord Roun Blud Balltmere MOHAN RUDRAPPA

MD

31. Date filed (Month, Day, Year)



Barles

State

Registrar

Registrar DHMH 17 Rev 1/2001

Box 68760,

P.0.

of Vital Records,

Division

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009

		•	For State Registrar		State	n iviai yiai			e of De		vientai ny	Reg. No	"7 1 1 1	9	38042
	Physici	an	1. Decedent's Nam	e (First, Middle,	Last)						2. Date of D Month	eath Da	ay Ye	ar	3. Time of Death
	/Medic		JoAn		L.		Engla				Novemb	er 2	8, 200	9	8:45 P M
	Examir	er	4a. Facility Name (i							cation of Death)		County of D		
			Greate 5. Social Security N		more Med	ical Ce			owson	Under 24 Hrs.	8 Date of B		Baltim		
	Funeral Director		385-38-4. Usual Residence of	584	1 ☐ M 2 💢 F	7. Age (m) 13.		Months		Hours Min.	8. Date of B (Month, D March	27 ,	1931		ace (State or Foreign ry) higan
	/land		10a. State	10b. County		10c. Ci	ity, Town or Lo	ocation						10	d. Inside City Limits
	the Marylan r 28a-f show	ţċ	Maryland	Balt:	imore		Tows	on							1 □Yes 2 🕅 No
2	or 28%)ire	10e. Street and Nu	mber				10f. Zij	Code			10g. Ci	itizen of What	Countr	ry?
>	th wit	la la	414 Ra	nge Road	1				21204				USA		
V	r dea	nei	11. Marital Status		12. Was Dec	edent Ever in U	J.S. 13.	Was Dece	dent of Hispa	anic Origin? (Si	pecify Yes or N o Rican, etc.)	10-	14. Race - A Black, W		
D JOANN 215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Evanirar must be notified at	Completed by Funeral Director	1 ☐ Never Marr 3 ☐ Widowed	ied 2 ☐ Marrie 4 🛛 Divorced	d 1 Tyes If Yes, G Year or I	2 📉 No ive	1	1 □Yes		Specify:	,		Specify:	Whit	
, , ,	2 hou	ted	/Cna	15. Decedent's	Education grade completed)	1	16a. Dece	dent's Usu	al Occupatio	n	16b. Kind of Busine				
215	within 7 iene. than "r	be	Elementary/Seco			(1-4or 5+)	life.	DO NOT u	se retired)	ng most of worl	King				
21	ed wi lygier ner th	ပ္ပ	12		5+		<u></u>	Teac					Educat	ion	
and	be fil	Be	17. Father's Name	(First, Middle, L		771			18		ne (First, Middle		n Surname)		
N X	should and Men s marke umatic	은	Gilman 19a. Informant's N	ame/Polationshi	A.	Thor	mpson 19b. Mailing Address (Stree.			Catharine		B.	or Town Sta		rrell
Ma	id 2 s Ith ar 27 is trau		William :					0	,		on, Mar	. ,			5000)
je,	f Health item 27 other tu		20a. Method of Dis	position		20b.	Place of Dispo				Date		ocation - City		vn, State
E_{Λ} Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or any hipury or other traumatic event, the Medical Evandrat must be once.		1 ☐ Burial 2 ☐ 4 ☐ Dona jon	Cremation 3 5 ☐ Other (Spe	B □ Removal from	State	lantic	Crem	atory	12/1	1/09	Gle	n Burn	ie,	Maryland
Bali	permit Depar Impor any In		600	weral Service Li	I XISA	1	2	Lemme a	nd Address o on Fun Pado	f Facility eral Ho nia Roa	ome of l	Dula	ney Va	lley vlar	y Inc. nd 21093
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	/Medical		resulting in death)	4	Due to	(or as a consec			55.46						
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50.	led sit	nine	Sequentially list co if any, leading to in cause. Enter Under that initiated events	nmediate erlying	Due to	(or as a consec	quence of):								
P.A	execur and al-trar	Examiner	that initiated events resulting in death)	Last	c	(or as a consec	quence of):							+	
68760,	cate be executed physician and the burial-transit	edical E		1	d	d									
_	rtifica ng ph as th	-	JE EENAN E.		t										-
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician//	23b. Was deceden in the past 12 1 Tes 2	F FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 Yes 2 Yes Yes								'y Day Year			
P.(d by tetach	Ph	9 Unknown Part II. Other signif		e contributing to	looth but not roo	culting in the	endorlying (nause siven i	n Port I	23a Did	Ltobacco	use contribut	Meto the	e cause of death?
ds,	w requires that the d been signed by the should be detached	Completed by	atrice	a- 1	buillat		sulang in the c	inderlying (ause given ii		3				ably 4 🗆 Unknown
00	w req	lete	den	with.							24a. Wa	s an	24b Wer	e autop	sy findings available
Re	The law cate has page 2 s	шо		muna							aut	opsy formed?	prior	to com h?	pletion of cause of
ital		Be C	25. Was case refer	red to medical					26	S. Place of Dea	1 ☐ Yes th (Check only		0 1 1	Yes 7	2 2 No
\	nysici nis ce direc		examiner?	No	Hospital:	Inpatient 2	BR/Outpatie	nt 3 🗆 D	Otto		ome 5 Re		6 Other	Specify)
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification: To	27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	th 5 Pending investiga		of Injury nth, Day, Year)	28b. Time of Injury	of M	28c. Injury at Work? 1 □ Yes	2 □No	28d. Describe	how inju	ury occurred		
visi	Atten r deat ector: by the	ifica	3 Suicide 4 Homicide	6 Could no	t be 28e. Place	e of Injury - At h	nome, farm, st	reet, factor						r Rural	Route Number,
ä	ital or ars afte ral Dir led in				Dulic	fing, etc. (Speci						оwп, Stat			
	ie Hosp 124 hou ie Fune iletely fi	Medical	29a. Certifier (Check only one)	1 M Certifying 2 Medical E	Physician: To the xaminer: On the and man	e best of my kn basis of examin nner stated.	owledge, dea ation and/or in	th occurred nvestigation	l at the time, n, in my opini	date and place ion, death occu	e, and due to thuring and at the time	ne cause(e, date ar	(s) and manne nd place, and	er as sta due to	ated. the cause(s)
	To th Withir To th comp	Me	29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, D								Day, Year)				
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	10		30. Name and addr			_ /	ph 23a) (Type,	Print)							
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	Sta Registr		31. Date filed (Mon	886	19	Registrar's Sign	bar	الما							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Novembe orae /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** Months 1 **X** M 2 □ F Jan 21, 1950 Maryland 217-54-3935 59 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Yes 2 No must be notified at N/A Baltimore Director Maryland 28a-f the 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ò U.S.A 21224 3706 Claremont Street 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ral", or iten Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify: Black þ 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education the Medical (Specify only highest grade completed) City of Baltimore Elementary/Secondary (0-12) College (1-4 or 5+) **Drug Counselor** ith and Mental Hygir 27 is marked other r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mariam Rice George Epps ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3706 Claremont Street Baltimore, Maryland 21224 Health a tem 27 is Valerie Epps item 27 r other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ₽ 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If it any injury or o oonce. 11/24/09 Baltimore, Maryland Arbutus Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate the diseas ions that caused the d Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Mys. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician an as the burial-to Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? has 2 | No 1 Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 1 / Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes ٥ this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? s after deatn.

s al Director: After the house of the funer. Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 24 hours the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 _ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only

State

within 2

Silvermor 32. Registrar's Signature 600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

Michae 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

one)

end manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

RES-000

09-09068 Tavon Fortune

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 38044

		- For State egistrar					Certific	cate of	Death			Reg. No.				50		000	1
Physicia		. Decedent's Nam	ne (First, Midd	le,Last)									Date of Dea Month		Year			e of Death 15 hr s	
edical Examin	er	TAVON MA	URICE	FORT	UNE								Month Novembe		c. County of	Death			┨
	4	a. Facility Name (Johns Hopl			reet and nu	imber)		41	b. City, Tow Baltimor		cation of	Death		41	c. County of	Death			
-	•	5. Social Security		6. Sex		7. Age (Ir	n yrs. last b	irthday)	If Under 1	Year	if Under	24Hrs.	8. Date of B	Birth(MM	/DD/YYYY)	g. Birtl	nplace	(State or	1
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shu maric event, the Medical Examiner must be notified at once	B	JOSEPH	J. WHI	ΓE, J	R.						DARN	ETTZ	FORT	UNE	City on Town	n Ctata	Zin C	inda)	-
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		21. Signature of F	uneral Service	e License	9	.1	0								S, JR.			1231	ļ
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Vital Recc ysician: The lav his certificate ha director, page 2	امها	25. Was case re	ferred to med	ical					2		of Death	(Check	only one)						_
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Division tal or Attendi rs after death.	Certification:	3 Suicide		ould not b	e			ne, farm, str	eet, ractory,	, once c	Juliulity, e	nc.	or Tov	vn, State	e) urley Stree	t. Balti	imore	, MD	
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ical	(Check only one) 2		xaminer:	On the bas	is of exam	knowledge nination and	, deam occ d/or investig	ation, in my	opinior	ı, death o	ccurred	at the time,	date and	d place, and	due to	the ca	use(s)	
To t With To t	Medical	29b. Şignature a	<u>·</u>		and manne	er stated		0			se number				9d. Date sig				_
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		30. Name and a	ddress of ner	son who o	ompleted c	ause of de	eath (Item 2	23a)											
31		Zabiullah	_		tant Med			111 Pe	nn Stree	et, Balt	timore,	MD 2	1201						
		31. Date filed (N			15		's Signatur	hark	1										
Regis	strai	DE	6016		Leve	w	13. 1	All Cares as	_						OCM	E			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Leah Μ. Fosdal November 09:00 PM 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Months Hours 219-83-3438 Jan. 27 2009 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3548 Brickwall Lane 21122 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jonathan Fosdal Shannon VanLeeuwen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan Fosdal (father) 3548 Brickwall Lane, Pasadena, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Dec. 01 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funcial Servi 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the d shock, or heart fa disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, after. List only called on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

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death with the Maryland

within 72 hours after

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permit. Pages 1 and 2 s
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Important: If Item 27 is
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Baltimore, Maryland 21215-0036

and burial-trar physician attending ase the ģ

law requires that the death certificate be executed

Hospital or Attending Physician:

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Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death)	a. Due to (or as a const quence		ma)	Zdays
Sequentially list conditions,	b. Chronic Lun		200	birth
il any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Concentul 1 Due to (or as a consequence	teart Disease		bith
	d Trisony 21			birth
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions of	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)	23	3d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco usi	e contribute to the cause of death? No 3□ Probably 4□ Unknown
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑No
25. Was case referred to medical examiner?		26. Place of	Death (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 ☐ DOA Other: 4 ☐ Nursi	ng Home 5 Residence 6	☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Time of Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 29a. Certifier 1 Certifying Phancol (Check only one)	ysician: To the best of my knowledgeniner: On the basis of examination a and manner stated.	e, death occurred at the time, date and and/or investigation, in my opinion, death	olace, and due to the cause(s) a occurred at the time, date and p	and manner as stated. place, and due to the cause(s)
29h Signature and title of certifier		29c License number	29d Date	signed (Month Day Year)

29c. License number

201010101010

29d. Date signed (Month, Day, Year)

21122

11.30.09

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) -doin Wiech

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ML

32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 38046 State of Maryland / Department of Health and Mental Hygien U Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year 10:13 AM November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA Beltmore Agnes HOSPITAL 9. Birthplace (State or Foreign Mary Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Hours May Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Explainment for realistical at 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 1076 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) ner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be aulkner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 permit. Pages 1 and 2 si Department of Health an Important: If item 27 Is 1 any Injury or other trau Windsor Mill nae Ircle salloping Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 4600 Heights MD 21207 low Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** numonia 1 day disease or condition resulting in death) Due to (or as a consequence of): /Medical Due to (or as a sonsequence of): Examiner 3mouths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Chronic obstructive pulmonary disease burial-tran Due to (or as a consequence of): the attending physician Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ abuse - Substance 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed coronary artery elesease 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has page 2 certificate 1 ☐ Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA of this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 Markes M Pango November 28 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimorco due 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For Amend Item 1 per dr., 8898, 12/01/09/hb Certificate of Death

Registrar

Reg. No. 38047 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** AIZONE FOWLKES 30 2004 07:30AM K. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner MD. CORR. INST-HAGERSTOWN Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 7, 195 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 51 213-72-8621 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show ar than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☑ No Washington Hagerstown Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 18601 Roxbury Road Hagerstown USA Funeral 12. Was Decedent Ever in U.SUNK
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give

1 ☐ Yes 2 ☒ No Specify: Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk unk (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth any jury or other traumatic event once. 17. Father's Name (First, Middle, Last) unk unk Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21746 18601 Roxbury Road Hagerstown, MD Md Correction Institution 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 3 □Removal from State Snecify) In State 1 ☐ Burial 2 ☐ Cremation 5 Other (Specify) ^¹ 4 □ Donation 21. Signature of Funeral Service ROTald, S. Wade ^{22. Name and Address of Facility} State Anatomy Board 655 W. Baltimore Street recter un Baltimore, MD 21201 Part 1. Enter the disease. Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEDATO CELLULAR CARCINOWA 3/20217ts **Physician** /Medical Due to (or as a consequence of): VIRTO INFECTION **Examiner** HEDMINS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ NECHON h20 AnTis 3 Probably 4 Unknown 1 🗌 Yes 2 NO Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 XYes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) VRISON Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Many er of Death 28a. Date of Injury (Month Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Yes 2 No death. 2 Accident after death filled in by the 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, atc (Specify) determined 4 Momicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MED DIR MCI H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MPH MN DRUCKINA 31. Date liled (Month, Day, Year) 32. Registrar's Signature State parks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Deatl 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY LEVINDALE 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 5. Social Security Number 6 Sex Date of Birth (Month, Day, Year) **Funeral** 10 M 20 F RUŚSIA 86 07/13/1923 Director 217-92-1504 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📆 No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 USA 1800 SNOW MEADOW LANE, #201 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Forces?

1 ☐ Yes 2 🏋 No

If Yes, Give

Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MECHANIC POWER CON 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MYNA KOGAN UNKNOWN FISHKIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other traus BELLA FISHKIN/WIFE 1800 SNOW MEADOW LANE, #201, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition HAR SINAI CEM. 11/30/2009 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 1. Signature of Fun ral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 e, or somplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a Part1 Enter the disease. shock, or heart failure. Immediate Cause (Final ROSTATE **Physician** Tru C (-1) disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2∐No 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2

State

Medical

29a, Certifier

HYSIC, AND

and manner stated.

29c. License number 00064533 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Min 2434 W. BELVHDERE BATIMONE M) 21215

BABATUN DE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC 0 1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Of IVI		rtificate of Death		Reg. No. 2009	38049
	Physicia		1. Decedent's Name (First, Middle, Last) Mary Adeline Gib	son		2. Date of Demonstrates Month	Day Year 26 - 2009	3. Time of Death 1:30 A
	/Medic Examin		4a. Facility Name (If not institution, give street and number, Golden Living Center		4b. City, Town, or Location of De	ath	4c. County of Dear	h
and the	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🖫 7. A	ge (<i>In yrs. last birthday</i>) 89 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi	rs. 8. Date of Bir	th 9. Bir ay, Year) Co	thplace (State or Foreign ountry) SOULI
	D .	_	Usual Residence of Decedent 10a. State	10c. City, Town or Lo	Taneytowr	1		10d. Inside City Limits 1 ☑Yes 2 ☐ No
3	with the	Il Direc	10e. Street and Number 62 Fairground Ave.		10f. Zip Code 21787		10g. Citizen of What Co USA	ountry?
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 128a-f show maric event, the Modical Examinat must be mailfed a	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 Fif Yes, Give Year or Dates:	No	Mas Decedent of Hispanic Origin? fYes, specify Cuban, Mexican, Pu t □Yes 2≹No <i>Specify:</i>	(Specify Yes or No erto Rican, etc.)		
Maryland 21215-0036	vithin 72 hot ene. Ihan "natur	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	dent's Usual Occupation kind of work done during most of v DO NOT use retired) Housewife	vorking	16b. Kind of Business Homemak	·
		Be	17. Father's Name (First, Middle, Last) Paul Sam		18. Mother's N Agne	Name (First, Middle es Brumf	, Maiden Surname) Lield	
Maryla	d 2 should be Ith and Mental 27 Is marked of traumatic ev	2	19a. Informant's Name/Relationship (Type. Print) Margaret Proctor-daugh		ng Address (Street and Number or Sairground Ave			
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev once.	77	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo	esition (Name of matory or other place) ew Mem Park 11			ll, NC
Balt	permit. Departi Importa any inji		21. Signature of ervice Licensee	2:	2. Name and Address of Facility 254 E. Main S		er Funeral minster,M	
	ifficate be executed Application and provided as the burial-transit as the burial-trans	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of): s a consequence of): s a consequence of): s a consequence of):	n accolin	the Di		Approximate Interval Between Onset and Death
	ath cerl attendin for use	by Physician/Mec		2 Fetal death 3 at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of d Month	elivery Day Year
ds, P.	uires that t signed by d be detad	d by Ph	Part II. Other significant conditions contributing to death	but not resulting in the t	underlying cause given in Part I.		tobacco use contribute Yes 2 □ No 3 □	to the cause of death? Probably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed				24a. Wa auto per 1 □ Yes	opsy prior to formed? death?	autopsy findings available o completion of cause of s 2 \Box
Vita	sician: certific rector,	æ	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpa	itient 2 ☐ ER/Outpatie	Others	Death (Check only	one) sidence 6 ☐ Other (S _k	necity)
on of	iding Phys th. : After this : funeral di	Certification: To	27. Manner of Death 28a. Date of It				how injury occurred	cony)
Divisi	al or Atter after dea Director d in by the	ertifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of	njury - At home, farm, si etc. <i>(Specify)</i>	reet, factory, office	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
	the Hospital or hin 24 hours afte the Funeral Dire mpletely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	s of examination and/or i	th occurred at the time, date and provestigation, in my opinion, death	place, and due to the occurred at the time	e, date and place, and d	e to the cause(s)
)	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	7	29c. License number	3	29d. Date signed (Mo	
			30. Name and address of person who completed cause of	f death (Item 23a) (Type	Print) West '	to no	11/27/2 P 2/15	7
	St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 0 1 2009 32. Reg	strar's Signature	parked	ren, in	-1113	•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38050 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year 6.20 PM Julietta Eigenia Ghee 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Social Security Number 16. Sex Baltimore If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Hours Min (Month, Day, Year) 1 □ M 🏋 🗆 F 214-64-7800 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits with the Maryland 1 Yes 2 No MO Windsor Mill Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3414 Maryvale Road 21244 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decesor... Armed Forces? 1 ☐ Yes 2 No k, White, etc. African-American þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Chemistry Techician Johns Hopkins Hospital and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earl William Anderson Alfreda Maddox 19a. Informant's Name/Relationship (Type, Print)
Clarence W. Ghee Jr./ Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3414 Marvvale Road, Windsor Mill, MD 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date cemetery, crematory or other place)
WoodLawn Cemetery 1 Burial 2 Cremation 3 Removal from State 12-4-09 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign fure of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 LibertyRoad, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. PMEUMONIA 1 day disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner NEUTROPENIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last 3 months UTERINE CANCER Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 4 Pregnant at time of death
9 Unknown 5 Other (specify) Month Day Year 1 Yes 22 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION DM, DEPRESSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? PULMONARY EMBOUSM 24a Was an performed certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ၉ 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res 000 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) Raven Balnimore, Mo, 21239 5601 Loch 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

901042093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia Alice Gunn NOVEMBER 24, 200 1:20P M Medical 4a. Facility Name (if not institution, give street and number)
Saint Joseph Medical 4c.County of Death Baltimore Examiner 4b. City, Town, or Location of Death Center 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Mar 13, **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Min. 1 M 2 M Months 71 Hours Country) Maryland Director 028-31-8434 1938 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Baltimore Towson 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21286 1538 Cottage Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Sheppard Pratt Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hospital Patient Account Rep. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Hand Dorothy Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Gunn /Daughter 1538 Cottage Lane Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Page 1 8 20c. Location - City or Town, State Nov Nov 1 Burial 2 Peremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2009 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Nancachidesoff Familia Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. 5 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SEPTIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILURE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequency of): Hospital or Attending Physician: The law requires that the death certificate be executed PNEUMONIA ending physiclan and use as the burial-tranthat initiated events Due to (or as a consequence of): Be Completed by Physician/Medical ACUTE MYOCARDIAL INFARCTION Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?
1 ☐ Yes 2 🗷 No 5 Other (specify) 4 ☐ Pregnant at time of death g ☐ Unknown Month Day Year been signed by the should be detached 1 ☐ Yes 2 ₽ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ISCHEMIC CARDIOMYOPATHY Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown LACTIC ACIDOSIS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performe death? RENAL INSUFFICIENCY Yes 2 N 1 🗌 Yes 2 💢 No Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 🗌 Yes 2 🔲 No after death Director: / Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 ho

To the Fune

completed fi (Check 3 [only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D31826 11-24-09

Registrar

6

State

RICHARD

31. Date filed (Month, Day, Year)

7601 OSLER DRIVE

TOWSON, MARYLAND 21204

M. D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINTHICUM,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 38052 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lucille K. Gease November 2009 8:40 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours (Month, Day, Yea Country) Ohio Director 291-09-2419 93 <u>Sept</u> 4 1916 Usual Residence of Decedent In than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No Maryland Harford Bel Air 10e, Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 128 W. Ring Factory Road Apt. 149 21014 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 Yes 2XNo Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve once. Albert F. Knapp Inez Paini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 W. Ring Factory Rd. Apt. 149 Bel Air, MD 21014 John H. Gease, Jr. / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State Evans Funeral Chapel place 109 4 Donation 5 Other (Specify) Forest Hill, Maryland Bel Air 21. Signature Funeral Service Licenses Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Immediate Cause (Final Physician/ Acciden erebro disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo 5 Other (specify) Month Day Year 1 Urknown should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifie 1/🚉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ourtifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

Amend Items 19a,b per sa,g898,12/07/09dhb,9,11,12 per fh
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #16a&B&19a&hMaryaANADDDarffffffff of Oldalt/09nd Mental Hygiene
Amend #5,15,17,18,20a-c,22, per FH C898,12/7/09 TT
Reg. No. 2009

			1 - State Amend #5,15,17,18,20a-c,22, per EH C898 12/7/09 T	T Reg	I. No. 2009	38053
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Ralph A. Graham	November	18, 2009	1:36 PM M
	Examin	er			4c. County of Deat	
Ť	Funeral		5305 Acorn Drive Camp Springs 5. Social Security Number (6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince (hplace (State or Foreign unitry) unit
	Director		314-32-9182 1X M 2 F 76 Yrs. Months Days Hours Min.	Feb 13,	1933 Inc	untry) unle liana
	pu 🛦 💮		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			Idod Inside City Limite
	laryla shov	ö				10d. Inside City Limits 1 ☐ Yes 24 No
	the N 28a-1	rect	10e. Street and Number 10f. Zip Code	100	. Citizen of What Co	
	3a or	i D	5305 Acorn Drive 20748		USA	unity.
	death	Iner	11. Marital Status Unic 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St. Armed Forces? Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St. Armed Forces) Unic 13. Was Decedent of Hispanic Origin? (St	pecify Yes or No-	14. Race - Ame	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, I're Medical Eventi activities to notified at once.	Completed by Funeral Director	1 Mever Married 2 Married 1 Married	nican, etc.)	Specify: wh:	
5-0	72 hc	etec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	sina 16	6b. Kind of Business/	Industry unk
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altimore,	ges 1 t of Hi if iten			Date 20	c. Location · City or	Town, State
텵	t. Pag rtmen rtant: njury		4 Donation 5 Stone (Specify) 12 Store Metro Crematory 12/4/	09 Ca	tonsville	, MD
Bal	permi Depai Impoi any Ir		21. Signature of Funefal Service Licensee Ronald S. Wade, Watertor State Anatomy Boar Baltimore, Marylan	y P <u>marc</u> d; 655 W. d 21201 2	n F.H. 27 Baltimor 1229	e Street Pass
			23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart failure. List only one cause on each line.	or respiratory arrest	t,	Approximate Interval Between
And the second	Physician		Immediate lause (Final disease or on thick)			Onset and Death
4	/Medical Examiner		resulting in death) Due to (or as a consequence of):	12		
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	uted	Examiner	Scale: Maily liet on Allower if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
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68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical	d			
	ertific	Mec	IF FEMALE:			
	attenc for us	sician/	23b. Was decedent pregnant in the past 12 months?		23d. Date of del Month	ivery Day Year
o.	that the de ned by the a detached f	ysic	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)			
σ,	s that ned b	y Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Division of Vital Records,	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	ed by		1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
900 000	e law requir has been s ie 2 should	Completed		24a. Was an	24b. Were au	topsy findings available
		E O		autopsy performe 1 🗆 Yes 🐉	d? death?	completion of cause of 2 □ No
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_	Shysi this c al dire	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho		ce 6 □Other (Spe	cify)
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<u>S</u>	al or / s after il Dire ed in b	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town, S	State)	na riodio ivamboi,
	To the hospital or Attending Physician: with 24 hours after death. To the Funeral Director: After this certification pletely filled in by the funeral director.	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cau red at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
1	To the within To the comp	Me	29b. Signature and title of certifier 29c. License number	7/. 29d	I. Date signed (Monta	h, Day Year)
			1)206	4	11/2	0109.
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1000	O.C.M	18. 2010
			31 Date filed (Month Date Veerback) 22 Registrar's Signature	TVDO.	1016411	

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u>26,2</u>009 Medical <u>Gilbert johnson Goetz</u> November 9:35A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 214-24-1355 1 🕅 M 2 🗆 F 80 Months Maryland Hours Min. (Month, Day, Year) Director Yrs October Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Nottingham 1 Tes 2 No Md. Balto, 0 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? with 23a Funeral 4104 Link Avenue 21236 USA items death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 14. Race - American Indian, Black. White, etc ò þ 1 Never Married 2 Married 1 X Yes 2 □ N If Yes, Give 21215-0036 1945-1948 1 Yes 2 No Specify: White 3 Nidowed 4 □ Divorced "natural" Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be flied within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event at 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Moore Electric Co, Electrician Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Goetz Nellie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Md. 21236 Gilbert J. Goetz Son 4104 Link Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Donation 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 11-30-2009 21. Signature of Fine a Service Licens Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician hroni disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, the burial-transit and resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physici eted filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 K No Hospital Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Cilchris 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by ☐ Homicide determined To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my policion death, and the cause(s) and manner as stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

2009

JOHNSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701 N. Char

32. Registrar's S

MI

Brish

31. Date filed (Month, Day, Year)

State

IDV

Registrar DHMH 17 Rev 1/2001

NELIA E. SANCHEZ

31. Date filed (Month, Day, Year) 32. Registrar's Signature

- ERESPO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

404

D0067697

EASTERN BLVD, ESSEY, MD 21271

11-27-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav BRANT LEE GREER 23, NOVEMBER 2009 2:16 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1**⊠** M 2□ F 216-94-8108 47 Apr. 27, 1962 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐Yes 2 TX No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 W. Jarrettsville Road 21050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elbert Bruce Greer Omie Irene Rutherford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Greer / Mother 305 W. Jarrettsville Road, Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn | 11-28-09 Bel Air, Maryland 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 23a. Part 1. Erner the disease, or complicative is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RETARDATION 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural

Physician /Medical Examiner Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylau Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner must be redifficed an once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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attending physician and for use as the buriat-transi cate has been signed by the page 2 should be detached

Physician/Medical

Completed by

Be

Certification: To

Medical

P.O. Box 68760

Vital Records,

Division

certificate has funeral director, After this al or Attendi s after death. Il Director: A filled in by the

2 Accident

3 Suicide

4 Homicide

1 ☐ Yes

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 23/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid Puthawalay 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

edistrar's Signatur

501 South Union St., Havre de Grace, MD 21078

State Registrar

within 24 hours a

To the Funeral C

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 38057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER STELLA GILLEY 2009 4:40 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH AND REHABILITATION <u>HARF</u>ORD FOREST HILL Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Ye 1 □ M 2 🛣 F , 1919 North Carolina Davs Hours Min. Director 246-22-2125 89 Usual Residence of Decedent show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No <u>Harford</u> Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2107 Moorland Drive 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 V Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Factory Worker Shoe Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ၉ Robert (nmn) Gilley Victoria (nmn) Beamon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel A. Jones / Sister 2107 Moorland Drive, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Ashelawn Memorial Gdn 12-3-09 West Jefferson, NC 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Inter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 032255

Registrar
DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box

P.O.

Records,

of Vital

Division

ROAD

BEL AIR, MD.

21014

MACPHAIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. DAVID DUNN

31. Date filed (Month, Day, Year)

615 W.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 30, 2009 Linda Maria Hannah 1:57 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carrol1 Westminster Dove House 5. Social Security Numbe 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours (Month Day Year) 70 **Director** 216-08-1638 39 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD. Carroll Mt. Airy 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1903 Tender Ct. 21771 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2***No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XNo Specify: If Yes, Give 3 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Federal Gov. Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked otl 18. Mother's Name (First, Middle, Maiden Surname) ပ Gail Patricia Douglas Romeo Munoz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1903 Tender Ct. Mt. Airy, MD. 21771 James Hannah/ Husband Department of Healt Important: If item 2 any injury or other 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carroll Crematory 12/04/2009 Winfield, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic 22. Name and Address of Facility Burrier—Queen Funeral Home 1212 West Old Liberty Road . P.A. 184 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition olon ancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Reno or Attending Physician: The law requires that the death certificate be executed as the burial-transi 11/28/01 - 11/30/01 resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 Nother (Specify) Dave House 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at . After 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Director: 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical

Division of Vital Records, P.O. within 24 hours

To the Funeral

> State Registrar

29b. Signature and title of certifie

29a, Certifier

only one)

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Year 12:15 A M Dorothy A. Hiltz December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Sykesville Fairhaven 8. Date of Birth (Month, Day, Year) 06/09/1930 5. Social Security Number 6 Sex f Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F 216-32-1908 79 MD. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 20. 100. 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD. Carroll Sykesville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 U.S.A. 7200 3rd Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Be Completed by Specify. Specify: 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine O'Neill George Herrmann ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1253 Hoods Mill Road Woodbine, MD. 21797 Thomas Hiltz/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1ÆBurial 2 ☐ Cremation 3 ☐ Removal from State 12/04/2009 Woodstock, MD. 4 ☐ Donation 5 ☐ Other (Specify) Alphonsus Cem. 21. Signature of Funeral 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 West Old Liberty Road Winfield, MD. 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death derebral varular accident Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHIOCEXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 □ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersburg 1643 Liberty

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

P.O. Box 68760

Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #Isper MD & 206 per Fh 8898 12/2/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year EDGER **Physician** 4: 43pm NOVEMBER 30 2009 Edgar Henry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL HARBOR BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Funeral Days Hours 1**X** M 2 □ F 09/26/1926 MD 212-20-8027 83 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Baltimore Halethorpe MD 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21227 4456 Annapolis Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □Xes 2 □ No If Yes, Give 1946—
Year or Dates 1946— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2√☐ No Specify. à 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Emma Snyder Edgar Booth Henry ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4456 Annapolis Road, Halethorpe, MD 21227 19a. Informant's Name/Relationship (Type. Print) Darlene Henry / Wife of Health a Item 2 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Department of Important: If It any injury or o Cedar Hill Cemetery Brooklyn, MD 12/04/2009 Bo-4 ☐ Donation 5 ☐ Other (Specify) Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Road, Halethorpe, MD 21227 M01452 Approximate Interval Between Onset and Death 4 Work 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preunonio **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ulmonary Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) cate has been signed by the i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 21 ☑ No 1 ☐ Yes 2 🗹 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NOVEMBER 30 2009 RES -00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Harover MD MIN 3001 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 1 2009

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day November 25,2009 **Physician** Robert Alan Hartmann 2:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3322 Texas Avenue Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Young)

Months Days Hours Min. Dec. 25, 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 ☐ F 216-30-0192 78 Director Usual Residence of Decedent show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Madical Evandare must be notified at Parkville Director Baltimore 1 ☐ Yes 2 ▼ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 3322 Texas Avenue Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BG&E General Repair Machinist 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any liny or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Mildred Beacham John William Hartmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3322 Texas Avenue-Parkville, Maryland 21234 Leslie Hartmann-spouse 20b. Place of Disposition (Name of cometery crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 11/28/2009 Parkville, Maryland 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Service Signature of Funeral Service License 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line.

Park Fail VIII 8800 Harford Road-Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cau 'e (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner RECULLANT PYLONOPHRITIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ATONIC BLADDOR nding physician and se as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CALDIONYOPATHY 2 No 3 Probably 4 Unknown 1 Tes Completed PARKINGON'S DISCASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Tyes Hospital or Attending Physician: '4 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending NA 1 ☐ Yes 2 ☐ No NA investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide NA within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) November 25, 2009 D0025010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21234 SERGIA R- NOLAN MO 8831 SATYL HICE RO # 100 BACTMORE LED 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOV 1409 2009 Hunter Henson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltiropes Hospita N/A 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/03/1943 5. Social Security Number 7. Age (In yrs. last birthdav) **Funeral** Days Min. 1**∑**M 2□ F Yrs. Director 212-40-0307 66 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, It a l'volica Evani ar nuel convolitio at 1 XYes 2 No Director Baltimore MD N/A 10e. Street and Number 10g. Citizen of What Country? 701 N. Arlington Avenue 21217 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Super Market 11th Grade Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental F ' is marked otl Be Henson ပ Unknown Hanna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important; If Item 27 is
any injury or other trau 2915 Stafford Street, Baltimore, MD 21223 Catherine White(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Western Star Cem. 12/02/09 Baltimore, MD 22. Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of): Examine burial-transi Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Year Month Day 5 Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 140 2 No 1 ☐ Yes 1 ☐ Yes Division of Vital the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P24057 GODA DAMERA 900 Coxton Evenue, Baltimore, MD 21229 Year) 2009 3. Registrar's Signature 31. Date filed (Month, Day, State Marke Registrar

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Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year itchman **Physician** acharia November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Months Days Hours Min 768-80-1096 Feb 25, 2009 Florida Director 2 9 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Yes 2 No Director Maryland Montgomery Clarksburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 5 'natural", or items 23a 13206 Catawba Manor Way 20871 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Yes Yes 1x Never Married 2 ☐ Married 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No \$ Specify Black 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Infant al Hygiene. Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental is marked Monique Coleman Raimondo Hitchman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 13206 Catawba Manor Way Clarksburg, Maryland 20871 Monique Coleman of Health If item 27 Baltimore, 20b. Place of Disposition (Name of Westmore Vander Services) 20a. Method of Disposition 20 R Location - City or Town, State /16 1X Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or Checterfield, Virginia 4 Donation Dale Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate shock or heart failu Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No detached 9 Unknown PO 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 2 **X**No 1 Yes certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA ည this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 24 hours after death. Funeral Director: After injury 1 X Natura I 5 Pending 1 Tes 2 No 2 Accident investigation completely filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 27 Marenber 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year) parked

32. Registrar's Signature

		For State Registrar	State of Ma	ırylanı		irtment of i tificate of		id Mental Hy	giene Reg. No.	009	38064
Physici /Medic		1. Decedent's Name (First, Middle, L. MELVIN JAC		OLL	AND			2. Date of De Month NOVEMBE	Dav	Year 2009	3. Time of Death 02:38:A M
Examin		4a. Facility Name (If not institution, gith HARBOR HOSPITA				4b. City, Town, o				County of Death	l
Funeral Director		218 03 3724		92	ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi (Month, D 11/09	rth ay, Year) 0/1917	9. Birth Con Ma:	nplace (State or Foreigr untry) ryland
e Maryland ia-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A			, Town or Loo Baltim					3	10d. Inside City Limits 1 XYes 2 No
th with the	Funeral Director	10e. Street and Number 3919 Inner Cir	cle			10f. Zip Code	21225		_	en of What Cou	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is in order to other traumatic event, it is in once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ X Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	lo	'	Vas Decedent of I f Yes, specify Cub ☐ Yes 2 🔀 No		? (Specify Yes or Nouerto Rican, etc.)		4. Race - Amer Black, White Specify:	
ithin 72 hc ne. nan "natu	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5-	+)	(Give life. L	lent's Usual Occu kind of work done OO NOT use retire	during most of ed)	working		nd of Business/I	•
filed wi Hygier ther th		17. Father's Name (First, Middle, Las	t)		Tax	i Driver	т——	Name (First, Middle		axi Service	
ild be i fental rked o tic eve	To Be	(not available)	Hol1	and.		Glenny (not avai					able)
2 shou and N Is mai		19a. Informant's Name/Relationship						or Rural Route Numi	er, City or	Town, State, Z	Tip Code)
1 and Health sm 27 ther tr		Sharon Bowman /	Daughter	Janh Di		West Yu		eet G1		e, Ariz	zona 85304
Pages ent of ht; If its y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		I		sition (Name of natory or other pla Crematory				•	Maryland
permit. F Departm Importar any Injur		21. Signature of Funeral Service Lice		Day		. Name and Addre		Gonce Fu			
89 E 29		+ Hens (1)	drudge	e_				ghway Bai	Ltimo	re, Mar	yland 21225
Physician /Medical		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CONG	e. EST	IVE	HEART			arrest,		Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to finine date cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	imon	NIA						3 DAYS
rificate be executed ng physician and as the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a	Due to (or as a consequence of):							
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal	death 3	Ectopic pregnand Other (specify)	су		2	ivery Day Year	
quires that an signed b uld be deta	þ	Part II. Other significant conditions	contributing to death bu	it not resu	ılting in the ur	derlying cause gi	ven in Part I.		tobacco us Yes 2□		the cause of death?
: The taw re cate has be page 2 sho	Completed							— 24a. Was auto perf 1 □ Yes		24b. Were au prior to d death? 1 □ Yes	topsy findings available completion of cause of
stctan certifi rector	Be	25. Was case referred to medical examiner? 1√Yes 2 □ No	Hospital:			Ott	hor:	Death (Check only	one)		
inding Phy ath. r: After this ie funeral d	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v T	ER/Outpatien 28b. Time of Injury	28c. Inju	iry at	ng Home 5 Res			cify)
Ital or Atterns after de ral Directo	Certification:	3 Suicide 4 Homicide 6 Could not be determined 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Record City or Town, State)								•	
Hosp 24 hou	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner state	examinat	wledge, death tion and/or in	occurred at the treatment occurred at the tr	ime, date and p opinion, death	place, and due to the occurred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
To the vithin To the comple	Me	29b. Signature and title of certifier 29c. License number RES - 001						29d. Date signed (Month, Day, Year) NOVEMBER 23 2009			
	- 4	30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, I		,				

State Registrar ZAW M IN , 3001 SOUTH
31. Date filed (Month, Day, Year) 32.

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

STREET

HANGUER 32. Fegistrar's Signature BALTIMORE, MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November 29, 2009 John C. Haigh 6:30 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number **Funeral** Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours June 26, Director 196-24-5155 79 Yrs Pennsylvania **1**930 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗘 No York New Freedom 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1265 Crown Point Court 17349 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black. White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) President Baltimore Bank Corp. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Severn Haigh Mary McGrenra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 1265 Crown Point Court; New Freedom, PA 17349 Bonnye L. Haigh injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🗔 Cremation 3 - Removal from State 4 Donation Other (Specify) Dulaney Valley Mem Gardens 12/4/09 Timonium, MD 21. Signature of Furera 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home. Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardiece on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition GALLBLADDER CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 욘 1 Tes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 2 Accident 1 🗌 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HAUF, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

NOVEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death HOFFMAN Physician/ NOVEMBER 28, 2009 WILLIAM 3:10A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days 0972671911 213-12-4522 98 Director MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland must be notified at Director MD MONTGOMERY ROCKVILLE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 6121 MONTROSE ROAD IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 V Yes 2 No
If Yes, Give
Year or Dates. the Medical Examiner Black, White, etc ō Completed by 1 Never Married 2 Married 21215-0036 1 Yes 2XXNo Specify: WHITE Specify: 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) TRANSPORTATION 12 PROPRIFTOR Be other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ **HOFFMAN** ANNA permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOIS NEUMAN/DAUGHTER 1705 PASTURE BROOK WAY, POTOMAC, MD 20854 Baltimore, 20b. Place of Disposition (Name of Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 11/30/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilityOL LEVINSON & BROS., INC. 18900 REISTERS<u>TOWN ROAD, PIKESVILLE.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final PNEUMON. Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown page 2 should be detached 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: ၉

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Records, Division of Vital s after death. filled in by within 24 hours a To the Funeral D

1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 🗌 No 1 Yes 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29d. Date signed (Month, Day, Year)
NOVEMBOR 28, 2009 29c. License number P 3 5 4 36 29b. Signature and title of certifier

(Hemyssa) (Type-Print) & RD, DOCKVILLE, MD 20812

State Registrar

Certificate:

Medical

aubane

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 N For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER STEPHANIE GIBBONS HARBOLD 2009 4:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER @ GBMC BALTIMORE IOWSON 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Year) 1950 Maryland 1 ☐ M 2 F 59 Months Min. Aug. 10, Hours Yrs Director 215-50-5039 Usual Residence of Decedent or 28a-f show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits be notified at 1 Yes 2X No Maryland Cecil Port Deposit ᡖ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral traumatic event, the Medical Examiner must 90 South Main Street 21904 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **y**o Specify: 3 ☐ Widowed 4 🏋 Divorced Specify: Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. other thar Elementary/Seconday (0-12) College (1-4 or 5+) Medical Recruiter Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Robert Gibbons Doris Burke Bradford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradford T. Harbold / Son 90 South Main St., Port Deposit, MD 21904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ridge Cemetery 11-25-09 Pikesville, Maryland of Funeral Service Lice McComas Funeral Home, P.A. Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition nset and Death anc Physician/ Igmou 1065 Medical resulting in death) Due to (as a consequence of) Examiner Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Records. No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performeda 1 🗌 Yes Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes Other: ျ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No neral Director; A filled in by the fi Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature and title of costifier 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hailes

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 () () 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 November 6:25 AM Robert Charles Hime 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last Harford Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 XM 2 □ F Months Days Hours Min. 079-12-8516 90 Apr. 17, 1919 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Eastern Avenue 21014 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 127 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Henry Hime Lessie May Peterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred R. Hime / Wife 202 Eastern Avenue, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 11-30-09 Darlington, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21014 21. Signatur of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death V. Tachi Nm guskuresp Immediate Cause (Final cerry throwas Cardiac disease or condition resulting in death) >1 day Due to (or as a consequence of): [Hypoalburinewig Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Colifis / Adult seps is Syndrome c. detticile Severe Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy performed? Yes 2 No

Physician /Medical Examiner Examiner

be executed

Important: If any Injury or once.

Physician

Examiner

Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

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/Medical

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the attending physician been signed by I should be detach

Completed by Physician/Medical

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Certification: To

Medical

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

Part II. Other significant	conditions contributing	g to death but not	resulting in the	underlying cause	given in Parl	t

examiner?	26. Place of Death (Check only one)			
1 Yes 2 No Ho	ospital: 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier (Check only one)	Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)						

Kamul Bangoria

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pper Checapeake Dr. Bel Air, mp 21014 Bangolamp-500 U

State Registrar

after death Director: ō

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Thomas Jubb 38069 1. For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 30, 2009 1305 hrs Medical Examiner Jubb Thomas 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Harford 415 Market Street Room 133 Havre de Grace If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country) MD 219-26-8224 71 Director 1 X M 2 4-29-1938 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No MD or 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once. Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 415 S. Market Street 21078 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White etc. Armed Forces' 2 Married 1 Never Married 2 X No Yes White 1 Yes 2 X No specify: Specify Divorced If Yes. Give Year 3 X Widowed marked other than "natural", event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Electronic Tech Johns Hopkins Hosp Baltimore, MD 21215-0036 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John C. Jubb Sr. Gertrude I. Weatherstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 7 8 19a. Informant's Name/Relationship (Type, Print) Victory Gallop Ct. Havre de Grace, Md. Thomas W. Jubb Jr. Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place)
Sacred Ht.of Jes. 1 X Burial 2 Cremation Removal from State 12-4-09 Baltimore, Maryland Important: injury or oth Donation 5 Other Specify: 22. Name and Address of Facility $\,$ Joseph $\,$ N $\,$ Zannino Jr. 21. Signatu me of Funeral Service Licenses Balto. Md.21224 263 S. Conkling St. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and (Medical Death a. Asphyxia Immediate Cause (Final disease "xaminer or condition resulting in death) Due to (or as a consequence of): b. Choking on Food Bolus Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED the attending physician hed for use as the burial Box 68760, 23d. Date of delivery IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ Yes 2 ✔ No 3 Probably 4 Unknown Hypertension, Dementia Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed' death? Yes 2 V No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other 4 Residence 6 V Other: Scene DOA ER/Outpatient 3 Nursing Home 5 Inpatient After this 1 V Yes To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funera 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject choked on food FOUND: Natural 1 Yes 2 ✔ No Pending 1250 hrs Nov 30, 2009 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 415 Market Street, Havre de Grace, MD (Specify) Nursing Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number December 1, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Alian, MD Assistant Medical Examiner 31. Date filed (Month, Day State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department / Department / Department / Department / Department / Departm	artment of Health and I rtificate of Death		ne 2009 380 7 0
	Physici /Medic		1. Decedent's Name (First, Middle, Last) SHIRLEY L JOHNSON	2. Date of Death Month	Day Year 12 50p M	
3	Examin		4a. Facility Name (If not institution, give street and number) MERCY HESPITAL	iTy	4c. County of Death BAUTI MORE CITY	
	Funeral Director		5. Social Security Number 212-84-1473 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	•	9. Birthplace (State or Foreign Country)
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	109-14-07	10d. Inside City Limits
	h the Mar	Funeral Director	MD NA Baltimon	e 10f. Zip Code	10g.	Marian of What Country?
	sath wit	eral D	1506 North Stricker Street	21217		USA
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event har must be halffind at once.	þ	Armed Forces? 1 □ Never Married 21X Married 1 □ Yes 2√2No	Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 XNo <i>Specify:</i>	oecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. African Specify: American
21215-0036	within 72 ho iene. than "natu he Modical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	o. Kind of Business/Industry Offices Leaning homes &
nd 2	be filed tal Hygi d other	BeC	10th_Grade NA Dome	estic. 18. Mother's Nam	e (First, Middle, Maid	
ıryla	should had Men market	ပ္	James Johnson 19a. Informant's Name/Relationship (Type. Print) Sister 19b. Maillin	Lucil g Address (Street and Number or Ru		enner
, Ma	and 2 sealth a n 27 Is		Delores Johnson- In Law 1533	N. Gilmor Str	eet Bal	timore, MD 21217
altimore, Maryland	t. Pages 1 tment of H tant: If iter jury or oth		4 □ Donation 5 □ Other (Specify) Arbutus	natory or other place) S Mem. Pk. 12-0)4-09 A1	c Location - City or Town, State
Ba	Depar Impo any Ir			$^{2.\mathrm{Name}}$ and Address of Facility W_{N}		
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
1	Examiner		Due to (or as a consequence of): HEPATITIS	C		
Sequentially list conditions, lary list in the data of the cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):						.,
38760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of): d			
. Box 68	leath certifice attending ph for use as th	w	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Live birth 3 Live birth 2 Fetal death 3 Live birth 3 Live b	Ectopic pregnancy		23d. Date of delivery
P.O.	uires that the dez signed by the a d be detached fo	Physician/M	1 Yes 2 No 9 Unknown Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 Yes	Other (specify)		Month Day Year
ords,	w requires that been signed should be de	ð	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Ξ	The ate h	Completed			24a. Was an autopsy performed 1 □ Yes 2 🗹	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
	Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatier		th <i>(Check only one)</i> ome 5 ☐ Residence	e 6 ∐Other (Specify)
sion o	9 je je	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) Injury		28d. Describe how in	
DIX	ital or Atres after de al Direct	Certifi	4 Homicide determined 200. Place of mjury - At rome, farm, street building, etc. (Specify)		City or Town, S	
/	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and in the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	Voth Com	Σ	29b. Signature and title of certifier Amiè Sessa, MD	29c. License number		Date signed (Month, Day, Year) Wem Nev 29, 2009
			30. Name and address of person who completed cause of death (Item 23a) (Type, 301 St. Paul Place Baltin		01	
	Sta Registra		31. Date filed (Month, Day, Year) DEC 0 1 2009 32. Registrar's Signature	and		

Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Box 68760,

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11,12,15,16a&b,17,18,20a=6.822 Perh Fill (1898 all A/glehle) JH State of Maryland Departifient of Health Fill (1898 all A/glehle) JH Reg. No. 2009 38071 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day 19 Andrew Johnson November 2009 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year March 23, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

 With the country of the country o **Funeral** 578-40-0786 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show MD Prince Georges Hyattsville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 4922 LaSalle Road 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? UNR 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: black 1 ☐ Yes 24 ☐ No Specify ģ 3 ▼ Widowed 4 □ Divorced Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural any Injury or other traumatic event, the Medical pope. 16a. Decedent's Usual Occupation Unit 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) علصيد unk Liquor Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Andrew W, Johnson ပ Magdelain 19a Informant's Name/Relationship (Type. Print)
Arthur Rochee / Cousin
Washington Adventist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10671 Green Mountain Circle Columbia, MD 2104412 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1**X** Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 □ Donation 3 Nother (Specify) In State 12/07/2009 Suitland, MD Stewart Funeral Home, Inc 21. Signature of Puneral Serving Ronal d 21201 Washington, D C 20019 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCIENTI Cardiovascular Diseas **Physician** ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ventilution Dependent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was and autopsy performed? Ves 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after upage...

To the Funeral Director: Af 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 01852 Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeensbury Rd Hyattsville MD 20781

DHMH 17 Rev 1/2001

State Registrar

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#12&20b, perFH, G898, 12/1709, WS

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NYVEWBEA Robert Johnson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Coci Perri ealth care syste 5. Social Security Number and 2014 Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 □ F Aug 23, 1938 Maryland 216-32-5303 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 XYes 2 □ No Glen Burnie Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 325 North Wellham Avenue 21061 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □ No Specify Specify. Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Trucking Company** Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Johnson Bernard Payne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 325 North Wellham Avenue Glen Burnie, Maryland 21061 Constance Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 12/1/2009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Domation 5 ☐ Other (Specify) 11/28/09 Arbutus Memorial Park of Funeral en ice Linens 22. Name and Address of Facility Synatur Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each frie. Do not enter the mode of dying, such as cardiac or respiratory arrest CARDIOMYOPATH Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) □Yes 2 No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown RTENS/ON 1 🗌 Yes SIDEROSI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 【 No PROST 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai P.O. Box 68760. physician the as attending ase for 1 ed by the a signed I Division of Vital Records, page 2 should has funeral director, n 24 hours after death.

e Funeral Director; Aftetely filled in by the fur within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Funeral

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28a-f

23a or

permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or is any injury or other traumatic event, the Modical Experimonce.

Physician /Medical

the Medical Examiner must be notified at

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Physician/Medical

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Completed

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Certification: To

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with the Maryland

Jame Knuwn to Mysiciani Johnson, Roberta Baltimore, Maryland 21215-0036

10 V

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr/me, g900,02/17/2010dhb 1- State of Maryland & Department of Health and Mental Hygieney 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29, **Physician** 12:10 P.M Donald Warren Jacobs Sr. 2009 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Tate Hospice House Linthicum 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/13/1924 7. Age (In yrs. last birthday) Funeral Months Days 1 M 2 □ F Hours Min. Mary land 216 18 4749 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Marter Examinar must be northed once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Anne Arundel Severn Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 U.S.A. 7670 Old Telegraph Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 TXYes 2 No If Yes, Give WW II Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. ρ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder W.R. Grace Co. 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Jacobs Minnie Peccora ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 Dawn Ponder / Daughter 5231 - 4th Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 12/03/2009 Cedar Hill Cemetery 21. Signature of Fu eral Service Lie Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Counadin Therapy **Physician** Isitia rerebral day / /Medical Due to (or as a consequence of): Examiner Treatment for Atrial Fibrillation with Complications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Division of Vital 1 ☐ Yes 2 DN 1 ☐ Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Yes 2⊈No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hoggs of Tour Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide l or A within 24 hours 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 559 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DOROTHY S. **JACOBS** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balhmore Ch hmore hmore Ti Under 1 Year If Under 24 Hrs. If Date of Birth (Month, Day, Year) 1916 7. Age (In yrs. last birthday) 93 Yrs. 5. Social Security Number brothy Jacobs **Funeral** 1 □ M 2**X**□ F MD 216-09-1425 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location death with the Marylan 10a State 28a-f shov 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number USA 7015 DEERFIELD ROAD 21208 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 □Yes 2 X No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME Known as 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BESSIE UNKNOWN SCHINDLER MORRIS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1749 N. WELLS STREET, #212, CHICAGO, IL 60614 BARBARA JACOBS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' Department of Important: If It any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM 11/29/2009 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ninutes **Physician** /Medical Due to (or as a consequence of): Examiner aorha if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed Muroscle burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMber 25, 2009

DHMH 17 Rev 1/2001

State

Registrar

Ave Zalhmake, MD 2/2/5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38075 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2009 Year Physician/ Month Day Leonard Joseph Kubski 28 8:00 A. M Nov. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1₺ M 2□ F Months Davs Hours Min Month, Day, 212-07-9258 95 Baltimore MD Director Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 1 Yes 2 No Baltimore County Timonium Maryland 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? be 23a Funeral Apt.101 21093 United States **Examiner must** 1 Dodworth Court items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Baltimore City Fire Elementary/Seconday (0-12) College (1-4 or 5+) the Battalion Chief Ith and Mental Hygien 27 is marked other to traumatic event, the N/A Department Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or မ Joseph Kubski Mary Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Squire Court Baldwin, Maryland Mr. Bruce V. Ensor (nephew) other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Nov.30, 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 S Cremation 3 Removal from State cemetery, crematory or other place) Evans Funeral Chapel Forest Hill, Maryland 4 Donation 5 Other (Specify) Name and Address of Facility acciful Alternatives Funeral&Cremation Ctr.,P.A 325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licen 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ heimer pars disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) physician sthe burial Physician/Medical that the death certificate be P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Hospital or Attending Physician: The law requires 2 Mo 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? cate has b autopsy this certificate 1 Yes 2 No 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner? 2 X No Other: 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Watural 5 Pending injury Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State)

Division of Vital

State Registrar

Medical

29a. Certifier

(Check

only one 29b. Sigrature and title of certifi

30. Name and address

31. Date filed (Month, Day,

3 L

Year)

of person who completed cause of death (Item 23a) (Type, Print)

🗡 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year 14 PM **Physician** 2009 Frank Joseph Kragl, Jr. 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSD Ha Baltimore Square Rosedale Lin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 **□** M 2 □ F 216-56-9685 Maryland Director 58 1951 June 7, Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Evanding In 1st be notified at once. 1 ☐ Yes 2 No Director Maryland Harford **Jarrettsville** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3820 Old Federal Hill Road 21084 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1981 – 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 2001 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Mechanic MD Army National Guard 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Joseph Kragl, Sr. Emily Ayers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Kragl / Wife 3820 Old Federal Hill Road Jarrettsville, MD 21084 altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 1, 2009 William Watters Meth. 5 ☐ Other (Specify) Jarrettsville, Maryland 4 Donation Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—Bel Air 3 Newport Drive Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cluse on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burnal-transit Diabetes Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) \(\frac{5}{\text{ Residence}} \) \(6 \) \(\text{Other} \) \((Specify) \) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

P.O. Box 68760 Division of Vital Records,

SON,

State Registrar

SHMH 17 Nev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

10 32. Registrar's Signatu

29c. License number

000

Square Drive Baltimore

29d. Date signed (Month, Day, Year)

			1 - State Registrar			Cer	tificate of	Death			Reg. N	10ZUU	9	38011
			1. Decedent's Name (First, Middle	e, Last)						2. Date of De				3. Time of Death
	Physicia		Jennie F. Kaye	S						MOV 2	4	oay 2009°	ar	3:30 A M
*10	/Medic		4a. Facility Name (If not institution	give street and number)			4b. City, Town,	or Location	of Death			lc. County of E)eath	
	Examin	er			de = 40				OI DCG.					
			Angel Gardens			46-4	If Under 1 Year	ville	24 Hrs.	O Data of Di-	-44-	Mont		
	Funeral		5. Social Security Number		e (In yrs. last bir		Months Days		Min.	8. Date of Bir (Month, Da	τη ay, Yea	(r) 9.	Counti	ace (State or Foreign ry)
	Director		333-05-6012		92	Yrs.			l l	Nov. 9	19	917	Wisc	consin
	p.		Usual Residence of Decedent											
	ylar		10a. State 10b. County		10c. City, Town	n or Lo							100	d. Inside City Limits
	Ma-fs	턌	MD Monts	gomery			Rock	ville						1 □ Yes 2/12XNo
	288.	Director	10e. Street and Number				10f. Zip Code				10g. (Citizen of Wha	t Countr	y?
	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		4101 Bel Pre H	Rd .			20	853			T	United	Stat	tac
	sath	Funeral		12. Was Decedent	Ever in II C	12 1			rigin? (Spor	oify Voc or No		14. Race - A		
	er d	un.	11. Marital Status	Armed Forces?		15. 1	Was Decedent of f Yes, specify Cul	oan, Mexica	n, Puerto R	lican, etc.)	,-	Black, V		
36	s aft	by F	1 Never Married 2 Marr	If Yes, Give	NO	1	I∐Yes 2∏XNo	Specify.	*			Specify:	W	hite
8	ura!	D L	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1								
ည်	72 h	ete	15. Decedent (Specify only highes	l's Education st grade completed)	16a.	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during mos	st of working	g	16b.	Kind of Busine	ess/Indu	istry
2	tthin le.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		_	ed)					_	
2	yd w /gier	Ö	12			Ana	lyst				Fε	ederal	Gove	ernment
b	~ = 0 =	Be	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name	(First, Middle	, Maide	en Surname)		
a	Mental Mental arked o	욘	Stanley	Kwjat	kowski			l N	lary			D	uda	
<u> </u>	2 should be filed wit n and Mental Hygien Is marked other th raumatic event, Tit		19a. Informant's Name/Relationsl	nip (Type. Print)	19b	. Mailin	g Address (Stree	t and Numb	er or Rural	Route Numb	er, City	v or Town, Sta	te, Zip (Code)
Š	d2: Itha 27 is trau		Michael H. Gree	Person	al l	1.6	88 Graa	ao Tor	70 Tn	Marc	sho1	11 77A	201	115
a)	1 an Hea em (20a. Method of Disposition	/Represe					Da			Location - City		
Baltimore, Maryland 21215-0036	ges it of		1 Burial 2 Tremation	3 Removal from State			sition (Name of natory or other pla							
Ē	Pa mer ant: ury		4 □ Donation 5 □ Other (S)		Chesar		ce Crema							MD
a	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.		21. Signature of uneral Service	Licensee		R 2	Name and Addi	ess of Facili	ity Cre	mation	Se	rvices		
m	89 = 89		1 Hoon	2		93	33 Gist	Ave	Silve	r Spri	ne.	MD 20	910	
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do									Approximate
			shock, or heart failure. List Immediate Cause (Final											Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	ial Fibi		ation							
	Examiner		,		a consequence		1 D							
	Examino	_	Sequentially list conditions.	b			cular D	ısease	=					
^	₽ ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		e consentence									
8	cute	am	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Ost	eoporosi	LS								_
Ó	certificate be executed iding physician and ise as the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):								
68760,	e be	/Medical		d										
28	ficat phy s the	ğ												
×	certi	Ž	IF FEMALE:	23c. If yes, outcome	of pregnancy							23d. Date of	delive	
ñ		ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death		Ectopic pregnar	су				Month		y Day Year
o.	the de	sic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	it time of death	5 ∟	Other (specify)							
<u>.</u>	law requires that the death as been signed by the atter 2 should be detached for u	Physicia								00- Did				
ທົ	gne gane	þ	Part II. Other significant condition	ins contributing to death b	ut not resulting ir	i the ur	nderlying cause g	ven in Part	1.					cause of death?
Vital Records,	en s									1 🗆	Yes	2 □ No 3 □] Proba	ibly XX Unknown
ပ္တ	s be	Completed								24a. Was	an	24b. Wer	e autop:	sy findings available
ž	The larate has	Ę								auto	psy ormed?	prior	to com	pletion of cause of
a	icate r. pa									1 ☐ Yes	2 1	No 1 🗆	Yes 2	2 □ No
=	Physician: The la r this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hannitalı					e of Death	(Check only o	one)			
	this of	၉	1 ☐ Yes 2 🙀 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	<u> </u>	it 3 🗆 DOA		ursing Hom	e 5 🗆 Resi	dence	6 ☐ Other (Specify))
_	ng P fter i	ä	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju	iry 28b.] y, <i>Year)</i> 8	Time of njury	28c. Inje	ıry at rk?	21	8d. Describe	how in	jury occurred		
Division of	ath. A:r	atic	2 ☐ Accident investig	ation				lYes 2□	No					
<u> </u>	Atte ecto by th	ific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 200. Place of inj	ury - At home, fa	rm, stre	eet, factory, office		28	Bf. Location (Street	and Number o	r Rural	Route Number,
ב	affer affer d in	Certification: To	4 I Hornicide	building, et	c. (Specify)					City or To	WII, Sta	ate)		
	spita nours nera / fille			g Physician: To the best										
	24 h	dic	(Check only 2 Medical one)	Examiner: On the basis of and manner st		d/or inv	vestigation, in my	opinion, de	ath occurre	d at the time,	date a	and place, and	due to t	the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29b. Signature and title of	1			29c. Licer	se number			29d. [Date signed (M	lonth, D	Pay, Year)
	⊬≯Fŏ		- X71 L	tan.				035792)					4, 2009
			1019									vo verime	T Z	
	1/2		30. Name and address of person							1		20050		
	10-		Swaroop G. Rao	, M.D.; 50 W	. Edmons	stor	Dr. #5)4, Rc	ckvil	le, MI) 2	20852		

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Kohn solomon 7:30 November 25 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltimore ST. Asnes Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Year) Days 219-62-6246 Marylan Director May Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show injury or other traumatic event, the Medical Examinar must be notified at 1XYes 2 □ No Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ **23a** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Des 2 □ No 1970 If Yes, Give Year or Dates: 1970 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 2 No 1973 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □ Yes Specify: 3 ☐ Widowed 4 Divorced 1975 nd Mental Hygiene. marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) abore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kohn ena ပ and M 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ge wood St. Department of Health au Important: If item 27 is any injury or other trau Baeto md. Kohnena 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatur Fun ral Service Name and Address of Facility Approximate Interval Between Onset end Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** sepsis Days /Medical Due to (or as a consequence of): Examiner 2 Days Bacterenuo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner lactic netabolic adidosis Days burial-trar Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical pheumenia 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 5 Other (specify) □Yes 2□No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à Solomon Camont 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thre

Coston

31. Date filed (Month, Day, Year)

Baltin

Registrar's Signatur

November 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar 38079 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 40 PM **Physician** 2009 Joseph Kapela 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Balti 39 yare HOSO, ta more ranklin If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1**X** M 2□ F 212-32-3872 74 November 18,1935 Maryland Director Usual Residence of Decedent the Maryland 10a State 10b County 10d. Inside City Limits 10c. City, Town or Location 28a-f show Examiner must be notified at Maryland Harford 1 ☐ Yes 2 ☐ Xlo Director Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21085 USA 720 Towne Center Drive 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥7Yes 2 ☐ No IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. nd 2 should be filed within 72 hours after alth and Mental Hygiene. 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 DoNo Specify: White ģ 3 Widowed 4 Divorced Completed traumatic event, the "Audical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Millwright Steel 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph John Kapela Elizabeth T. Sosnowski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 720 Towne Center Drive, Joppa, Maryland 21085 Margaret Kapela wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November permit. Pages Department of Important: If it any Injury or o 1 Daurial 2 □ Cremation 3 □ Removal from State Holly Hill Memorial 4 Donation 5 Other (Specify) 30, 2009 Middle River, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listipally one cause on each line. Immediate Cause (Final Physician Acute Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Organ tiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Sis physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident ours after death.

neral Director: A
filled in by the for death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a 000

State Registrar Dr. Arungari 31. Date filed (Month, Day, Yea

DHMH 17 Rev 1/2001

V

9000 Franklin Square Drive Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per fh 8898 12-1-09 yt State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 300 M ARIO IRD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Tate Hospice Linthicum 8. Date of Birth (Month, Day, Year)
Jan. 28,1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Davs Maryland Months Director 218-22-7762 82 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Illustical Evantings must be notified as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 2921 Golden Fleece Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) 12 Electrical Assembler Defense Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Jory Gladys LaBarre ည Monroe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark J. Stocker (Son) 2921 Golden Fleece Drive Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/27/09 Glen Burnie, Maryland Atlantic_Cremation 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 Z No 9 ☐ Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by BREAST 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify) HOSAIC Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27, Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Natural 2 ☐ Accident (Month, Day, Year) 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation in my antique death account of the cause (s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d/Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) w 1LHARZ J N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month SR. CHARLES LEWIS November 12:49 p^M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 8275 Baltimore Annapolis Blvd. Anne Arundel Pasadena If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 □ F 81 November 2, 1928 Maryland 214-24-6558 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21122 U.S.A. 8275 Baltimore-Annapolis Blvd. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces l MYes 2 □ No fYes, Give 1 Never Married 2 Married White 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Darcars Inc. auto Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecilia Karwoski Charles A. Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8275 Baltimore-Annapolis Blvd. Pasadena, Maryland (Wife) Chela M. Lewis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 🕷 Burial 2 🗌 Cremation 3 🗋 Removal from State Meadowridge Mem. Park Dec. 01, 2009 Elkridge, Maryland 4 Donation 5 Dother (Specify) Signature of Euper I Service Licens 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 my 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Import diate Cause (Final Jan ase or condition sulting in death) Due to (or as a consequence of) to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy Month Dav Year 5 Other (specify) □Yes 2□No 9 Unknown

Physician /Medical Examiner

law requires that the death certificate be executed

been signed by the attending physician should be detached for use as the buria

page 2 s

this

after death

Director:

Physician/Medical

<u>م</u>

Completed

Be

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Certification:

Medical

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

Box 68760

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of Vital Records,

Division

or Attending Physician:

Hospital To the Funeral

death.

permit. Pages 1
Department of H
Important: If ite
any Injury or ot

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

death 1

Director

Funeral

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Completed

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exam and burial-trai

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I
Dimentia	
Atrial to Trailly Sian	

abetes 25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 ☐ Could not be

DEC 0

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ Yo 26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

24a. Was an

🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and panner stated.

29b. Signature and title of certifier ari)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3708 mountain Road Pasadera, mo 21122 deborga Chr. Sto Sher d
31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	 . 7 -
Gregory Stelwyn Luckett	State

regary aterwyri	1	State of Maryland / Department of For State Certificate of Maryland / Department of For State		Reg. N	<u> 2009 3808</u>
Physicia Medical Examir	ın/	Decedent's Name (First, Middle,Last)	T	2. Date of Death Month Da	y 2000 Year 1153 hrs
nedical Examin		GREGORY STELWYN LUCKET 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
		South River / West River	Edgewater	2. Date of Death North Day Year November 16, 2009 1153 hrs	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		_	Country)
Director		213-50-3657 1 M 2 F 49 Yrs	S	05/24/	1960 Maryland
any	ŀ	10a. State 10b. County 10c. City, Town or Local	tion		
Aaryland 28a-f show	5	MD Anne Arundel Pasac			
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number	10f. Zip Code	10g. 0	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once			as Decedent of Hispanic Origin? (S		14. Race - American Indian, Black,
death v	Funeral	1 Never Married 2 Married Armed Forces? If Yes 2 No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.
s after	by F	.or Dates:		work done 16	
2 hours			nost of working life. DO NOT use ref		
5-0036 led within 72 tygiene. other than the Medical	Completed		Pile Driver		Construction
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)			,
212 Jild be Mental marke	o Be	Eugene Luckett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	The state of the s		
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours at nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural other traumatic event, the Medical Examin		Joyce Anderson/Fiancee 8656	Head Harbour,	Pasaden	a, MD 21122
re, l S I and of Heal of Heal		1 Burial 2 Cremation 3 Removal from State crematory or o			
Pag Pag ment tant:		4 Donation 5 Other Specify: Bavview	Crematory 11	/24/09	Baltimore, MD
Balt permit. Depart Import injury					
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart Approximate Interval
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Drownink</u>			Death
,		or condition resulting in death) Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
_	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, reate be executed sphysician and the burial - transit		d			
60, ate be ex hysician e burial	Medical		ermE, g898 12/17	7/09 TT	23d. Date of delivery
3876 rriffcat ling ph	an/IN	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregr	nancy	Month Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)		
that the death certificated by the attending		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?
s, P.O. nres that the signed by d be detact	ed by			2.47272223	2 No 3 Probably 4 Unknown
cords, law requir has been s	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
tal Rec cian: The la certificate h	Com			1 ✓ Yes 2	
Vital Rec ysician: The l his certificate l	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatie	26.Place of Death (Checont 3 DOA Other, Nurs		esidence 6 🗸 Other: Scene
of Viring Physical After this	To	27. Manner of Death 28a. Date of Injury (Month, Day Year)		28d. Describe how	w injury occurred
ion tendin tor: A the fu	atior	Natural 5 Pending 11/5/09 4:05 p	om 1X Yes 2 No	subject d	
Division of Vital Records, pital or Attending Physician: The law require ours after death. reral Director: After this certificate has been si filled in by the funeral director, page 2 should b.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	reet, factory, office building, etc.	or Town, Stat	eet and Number or Rural Route Number, City
Division of All Spirits of All Spiri		29a. Certifier 4 Certificing Physicians. To the best of my knowledge, death occ	surred at the time, date and place, a	·	ver, Edgewater, MD s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Mospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	ation, in my opinion, death occurred	d at the time, date an	d place, and due to the cause(s)
	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		(& Outerland)	O.C.M.E.		November 17, 2009
		30 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 21	201	
s	tate	24 P. di time de la companya Cinatura de C			
Regis		31. Date trace in Day, 1999			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONEGO MONEGONITRY ROL if Under 24 Hrs. Social Security Number 6. Sex 7. Age (În yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1**X**M 2□ F 83 214-94-1163 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the "Medical Examiner must be notified at 1 XYes 2 □ No Funeral Director MONEGOME 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2085 USA 6001 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify ۵ Specify: #5/ #A/V 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event, the Marie once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUONG ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M71 N H MHAN 9111 WHEATFIELD GERMHNITOWN Baltimore, Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 30-09 BELTSVILLE, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner HERATOCELLULAR CARCINOMA LETASTATIC Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.O. detached 1 ☐ Yes 2 ☐ No 9 Unknown r signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 4 Unknown 2 🗌 No 3 Probably page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 No 2 □No 1 Yes 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PICE 1☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D6374 NOVEMBER 27 2009 - KOLLEL hou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOU177 6 600

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

09-09164		Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Leg	ible.	
Tevin Logan	4	State of Maryland / Department of Health and Mental Hy- For State Certificate of Death		200	100001
	R	egistrar	Reg 2. Date of Death	J. No. 201	3. Time of Death
Physiciar Medical Examine		Tevin	Month November		0210 hrs
		a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	7 -
,		Johns Hopkins Hospital Baltimore		N	17+
runeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY 9. Bi	rthplace (State or Foreign ountry)
Director	2	918-53-4457 1XM 2 F 5 Yrs.	August	16,1944	Mary Iana
any	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
_1		MD NA Baltimore			1 Yes 2 No
or 28a-f show	홠	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
th the Maryland 23a or 28a-f sho	Funeral Director	2006 E. Belvedere 21239		USA	
ms 23a	era -	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame White, etc.	erican Indian, Black,
r death	딃	Never married 2 married 1 Yes 2 No		Specify:	lack
s after ral", miner	<u>ا۾</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	16b. Kind of Business	s/Industry
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	tired)	- 1	
5-0036 led within 7 Hygiene. other than	힐	9th Student	<u>'</u>	Educ	action
5-0 led wi Hygie		17. Father's Name (First, Middle, Last) 18.Mother's Name	e (First, Middle, N	Maiden Sumame)	
2121 ould be fi Mental marked ic event,	Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Num	OGCII)	ite, Zip Code) 2123
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f she redeer traumatic event, the Medical Examiner must be added a none	٩	Elona Logan-mother 2006 E. Belve		Baltin	rece Mi
and 2 and 2 fealth item 2 traur	t	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
nore ages l mt of l other		Bunal 2 Cremation 3 Removal floril state Vice New Avia DR 12	3/09	Baltin	nou, mi
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	ŀ	4 Donation 5 Other Specify: 21 Sign re of Funeral Service I consee 22. Name and Address of Facility	owell	Funera	2 Home
P Per III	1	Mun K. Amuel Sl. 3331 Brehms"	In E	altimore,	mD 21213
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	est, shock, or neart	Approximate Interval Between Onset and Death
/Medical -xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) Output (or as a consequence of):			Deati
		D			
	je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			1
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
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oe exection a cian a	dical	X UNPENDED	/09 TT		
760 icate b icate b	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Was decedent pregnant in the		23d. Date of deliv Month	ery Day Year
certif	sician/Medi	past 12 months? 1 Live bitth 2 Fetal death 3 Ectobic pregress 4 Pregnant at time of death 5 Other (Specify)		4	
ecords, P.O. Box 68760, he law requires that the death certificate be are has been signed by the attending physiciage 2 should be detached for use as the buri	Physi	1 Yes 2 No 9 Unknown 9 Unknown			to Manager of Jackbo
P.O. ss that the gned by the detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_	s 2 No 3 P	to the cause of death?
S, D	ed		24a. Was		autopsy findings available
ord w req as bee	Completed		autor		to completion of cause of
Rec The Is cate h	ĕ		1 ✔ Yes		Yes 2 No
n of Vital Records, P.O. Box 68760, fing Physician: The law requires that the death certificate be executed. After this certificate has been signed by the artending physician and funeral director, page 2 should be detached for use as the burial - transit	Be (25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other, 1 Nurs	sing Home 5	Residence 6 Of	ther:
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on on on on on on the control of the	ion	1 Natural 5 Deading (Month, Day, Year)	subject	t hanged s	elf
Division tat or Attendi us after death.	ficat	2 Accident Investigation Investigation 3 X Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or	Rural Route Number, City
Div itat or urs aff	Certification:	3 X Suicide 6 Could not be determined (Specify) residence	Baltimo	ore, MD	Rural Route Number, City Belvedere Av
Division of Vital I the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certif apletely filled in by the funeral director,	alc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	nd due to the cau	se(s) and manner as	stated.
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier.	a at the time, date	29d. Date signed (
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		November 29,	
				1.0.0000	
N. I		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201		
V (V	tate	31 Data filed (Membles Day Year) 32. Begistrar's Signature			
Regist		31. Date filed (Mostly Pay Year) 2009 32. Fegistrar's Signature			
DHMH 17 Rev 1/20	001	ORIGINAL		OCME	

Physician /Medical Examiner

Funeral Director

Herry J. Leubecker November 26, 2009 8:42 A.M. As Capture of Death As County of Death		For State Registrar		State o	of Maryland	d / Depa	artmen	t of H	ealth a	and N	•	/gien	ie .		9	8085	5
## Freity New Countries and anothers 4.0 City, Town or Location of Death 4.0 Country of Each 4.0 Country		1. Decedent's Nam	ne (First, Mida	lle, Last))av	Vear	3.	Time of Death	
de Cipt, Source (Constrol Character) 15.05 Northam Court 15.05 Section Security Number 21.6-10-25-564 15.05 Northam Court 15.05 No	an al	Henry	J. Le	ubecker											8:4	12 A.M. ^M	1
The process of the	er				mber)					of Death		4		,			
Description of Description	-									24 Uro	T 0 D-1 (D)		Ha			/Ot to E	
Top State County		216-10-9	564								(Month, D	ay, Yea	r) 18	Co	untry)	_	n
The present of Numbers The present The present of Numbers The present The p				/	10c. City	. Town or Lo	ocation								10d. In	side City Limits	
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Albert Leubecker Section Sectio	Be			, Last)					18. Moth	er's Nam	e (First, Middle	e, Maide	en Surr	name)			
Betty Leubecker / Wife 1505 Northam Court Bel Air, Maryland 21014 20a. Marbod of Disposition 1505 Northam Court Bel Air, Maryland 21014 20b. Marbod of Disposition 1505 Northam Court Bel Air, Maryland 20c. Location city or Town, State 20c. Location city or Town, State		Albert	Leubec	ker					Ann	ie I	'halheir	n					
20. Method of Disposition (Seption 2) Control		4					•	'						,	•	9)	
Sequentially is conditions Section Secti		ļ		r / Wife	Tool: Di											· · · · · · · · · · · · · · · · · · ·	_
22. Name any Address of Facility BVAINS Funeral Chapel & Cremation Service—Bel Air 3 Newport Drive Forcest Hill, Maryland 21050 23a. Part Lefter the disease, or compiler as that caused the death. Do not enter the most of dying, such as cardiac or respiratory arest, promoted course (final resulting in death) Approximate special promoted and the death of the most of dying, such as cardiac or respiratory arest. Approximate special promoted and death of the most of dying, such as cardiac or respiratory arest. Approximate special promoted and death of the most of dying, such as cardiac or respiratory arest. Approximate special promoted and death of the most of dying, such as cardiac or respiratory arest. Approximate special promoted and death of the most of dying, such as cardiac or respiratory arest. Approximate special promoted and death of the most of dying, such as cardiac or respiratory arest. Approximate special promoted and death of the most of dying, such as cardiac or respiratory arest. Approximate and death of the most of dying, such as cardiac or respiratory arest. Approximate and death of the death o		1 Burial 2	Cremation		State I _						•			-			
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25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	cal	Immediate Cause disease or conditi resulting in death) Sequentially list or cause. Enter Und Cause (Disease o that initiated event	(Final on	a	(or as a consequ	ence of):	NAK	2 y	A Q	2TE	12 y	Di	SE	rs6		val Between et and Death	<u>5.</u>
26. Was case referred to medical examiner? 1	nysician/Med	23b. Was deceder in the past 12 1 🗆 Yes 2	2 months? □No	1 ☐ Live 4 ☐ Pre	birth 2 Petal gnant at time of d	death 3			/			ű	23d.			Year	_
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	d by P	Part II. Other sign	ificant condit	ions contributing to o	death but not resu	ilting in the u	underlying c	ause give	en in Part	l.							n
1 Yes 2 No	Complete	25 Was case refe	arrad to modio						96 Fl.		aut per 1 □ Yes	opsy formed 2		prior to death?	complet	tion of cause of	е
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describ		examiner?	4	Hospital:	Innatient 2□	ER/Outnatio	ent 3 🗆 Do	Othe	ar:		No.		6 □	Other /San	cifu)		_
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY-S. NAIR M.D. 602.S. ATWOOD Rd. BELAIR MD21014 te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	n: T	27. Manner of Dea	ath	28a. Date	of Injury	28b. Time of		8c. Injury	y at	iursing ri				· · ·	city)		_
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY-S. NAIR M.D. 602.S. ATWOOD Rd. BELAIR MD21014 te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	atio		5 ☐ Pendi inves	ilig i	ntn, Day, Year)	ınjury	М]No							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY-S. NAIR M.D. 602.S. ATWOOD Rd. BELAIR MD21014 te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ertifica			minod 28e. Plac	e of Injury - At ho ling, etc. (Specif	me, farm, st	treet, factory	, office			28f. Location City or To	(Street own, St	and No ate)	umber or R	ural Ro	ute Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY-S. NAIR M.D. 602.S. ATWOOD Rd. BELAIR MD21014 10. 10. Date filed (Month, Day, Year) 32. Registrar's Signature	edical C	(Check only	Certify Medica	I Examiner: On the	basis of examina	wledge, dea tion and/or i	ath occurred nvestigation	at the tir	ne, date a pinion, de	and place eath occu	e, and due to the	ne caus e, date	e(s) and and pla	d manner a	s stated	I. cause(s)	
te 31. Date filed (Month, Day, Year) 32. Registrars Signature	M	29b. Signature a	tive of certifi	/ // /	endu	ng	290	Licenso	e number	44	4	29d.	Date si	gned (Mont	h, Day,	e (State or Foreign and Inside City Limits 1 Yes 2 No Indian, The land Party Indian, The land Party Indian Air Instate Instate	1
te 31. Date filed (Month, Day, Year) 32. Registrars Signature		VIJA	7Y-5	. NAIR	M.D.	602	, Print) 2.S	AT	Woo	2)	Rd.	BE	L	AIR	M	02101	4
		31. Date filed (Mo	ntn, Day, Yea	000	negistrars Signa	ture											

DHMH 17 Rev 1/2001

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Year 11 3 2009 4c. County of Death 4b. City, Town, or Location of Death se Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🖾 F 96 Nov.22,1913 Maryland

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 800 Thelma I. Leitch /Medical 4a. Facility Name (If not institution, give street and number) Examiner FRANKLIN SQUA Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 214-12-4114 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ortant; if item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Erand at a usal to notified at 1 ☐ Yes 2 DiNo Director Baltimore Maryland Baltimore 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number with 21221 1 Eastern Boulevard America Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No White \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Clerk Baltimore City Gov. 08 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental George F. Reter Lydia E. Gosnell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 9555 Shirewood Court Baltimore, Maryland 21237 Mrs. Alvina G. Lazzara Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial 20c. Location - City or Town, State 20a. Method of Disposition Date November Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Burnie, Maryland 30, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility eaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final persenden **Physician** disease or condition resulting in death) /Medical Due to (or an equence of): Examiner Vascula Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed ment and burial-trar Due to (or as a consequence of) attending physician Box 68760 De Physician/Medical the ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lo. Day in the past 12 months? 1 ☐ Yes 253 No Month Year 5 Other (specify) P.O. ned by the 9 Unknown signed by t 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has autopsy performed; 1 □Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nopatient 2 ☐ ER/Outpatient 3 ☐ DOA ည this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t Certification: After 1 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an 23 M.D 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

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31. Date filed (Month, Day, Year)

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egistrar's Signatur

FRANKLIN Square DR Balto

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38087 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Ida Virginia Lee 4:17 A. [™] 2009 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5217 Kramme Avenue Baltimore Anne Arundel 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/08/1923 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Maryland Months Days Hours 1 □ M 2 🗓 F 85 217 14 9651 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exprinter must be notified at once. 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Anne Arundel Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 5217 Kramme Avenue 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Burke Edna Kronberger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Lee / Son 5217 Kramme Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland MD State Veteran Cem. 12/01/2009 21. Signature of Fugeral Service License Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): nis certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Euwent strokes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□ Yes No Hospital: Other: 4 \(\sum_{\text{Nursing Home}} \) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0 Division of Vital Records, within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral o

> State Registrar

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

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Ritchie

and manner stated

8028

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- MD

M Dodg

Year)

🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

suite 134 Pasadera MD Z/122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 38088 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 27, **Physician** LONDON NOVEMBER 2009 11:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** LEVINDALE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/13/1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**] M 2□ F Days Min. Months Hours 86 082-14-3440 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or Items 23a or 28a-f show event, "to Medical Examiner must be notified at MD BALTIMORE BALTIMORE 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6619 CHIPPEWA DRIVE 21209 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: Maryland 21215-0036 1 □ Yes 2 No Specify. Specify: WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Ment once. Elementary/Secondary (0-12) College (1-4or 5+) **CUTTER** GARMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LIFSHITZ FANNIE LIPSHITZ ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELSIE LONDON / WIFE 6619 CHIPPEWA DRIVE BALTIMORE, MD 21209 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 11/29/2009 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MAURS disease or condition resulting in death) /Medical Die to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical The law requires that the death certificate the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year ed by the a detached f 5 Other (specify) Ö 1 ☐Yes 2 ☐ No. 9 Unknown σ. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page ; performed 2 No 1 ☐ Yes 2 🗆 No or Attending Physician: After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 1 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu r death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 025039 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of MA 2835 J UliAn JAKO 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible AMEND ITEM#19aperFH, G898, 12/3/09, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. Amend Item 26 per dr., 8898 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** AM 2009 TITEL /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner OAD OEWA 7122 tare bor If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months **≱**M 2□ F Director April 14,1947 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, II * Nextical Examinations to the province of Director 1 ☐ Yes 2 No MA ANNE ARCHOSER Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Bar Harbor Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 MYes 2 No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No ð Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Police Department State Trooper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cort John Miller 2 Sheila Jacqueline Hedrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Mrs Darlene L. Miller/ 11 Bar Harbor Road Pasadena Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State November 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 25, 2009 Brooklyn, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** metastatio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, in the limit class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burlal-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 **N**No 1 ☐Yes 2 No 1 ☐ Yes After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient /Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deam (Item 23a) (Type, Print) SADIO QIWEI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MEININGEI Worth V Physician /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Baltimore Randallstown Northwest Hospital If Under 1 Year 8. Date of Birth (Month, Day, Year) 5 – 18 – 1925 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Months 213-32-9867 Yrs. 84 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State ed other than "natural", or items 23a or 28a-f show event, the Medical Evanings must be notified at Yes 2 No Director MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 79B Pennsylvania Ave. 21157 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) School Elementary/Secondary (0-12) College (1-4or 5+) Water Specialist 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 Is marked other any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neva L. Meininger-wife 79B Pennsylvania Ave., Westminster, MD 21157 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD South Carroll Crem.11-27-09 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home D. 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) d **Physician**) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami and Due to (or as a consequence of): P.O. Box 68760. the attending physician thed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🥦 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death ad Other: SA SU Nursing 1∐ Yes 2 100 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and addr s of person who ompleted cause of death (Item 23a) (Type, Print) DO B 25 MO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

09-09064 Charles Mackall		delible Ink. Ensure All Cop rtment of Health and Mental tificate of Death		09 3809
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year November 21, 2009	3. Time of Death 1526 hrs
	Facility Name (if not institution, give street and number) Md. General Hospital	4b. City, Town, or Location of De Baltimore		ath
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. late 2 1 7 - 4 4 - 4 1 9 5 1 X M 2 F		Min. For	Birthplace (State or eign Country) MD
/ any		Town or Location		10d. Inside City Limits
cyland a-f show t once	MD Ba1	timore 10f. Zip Code	10g. Citizen of What C	1º Yes 2 No
the Ma tiffied a	HOWARD ST.	21217	USA	
or death with the Maryland or items 23a or 28a-f show trust he notified at once.	11. Marital Status 12. Was Decedent Ever in U. 1 Never Married 2 Married Armed Forces?			erican Indian, Black,
safter de ral", or niner mu by Fu	3 Widowed 4 Divorced If Yes 2 X No	1 Yes 2 X No specify:	Specify: B1	ack
5 72 hours n "natur al Exami leted k	Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		s/Industry
5-0036 led within 7 Hygiene. I other than the Medica	12	Custodian	Hospita	1
ID 21215-003 should be filed within and Mental Hygiene. 7 is marked other the matic event, the Med natic event, the Med To Be Comp	17. Father's Name (First, Middle, Last) Vernon Mackall	18.Mother's Na Mary N	me (First, Middle, Maiden Surname) Nirgan	
ilmore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Taut: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To other traumatic event, the Medical Examiner must be notified at once	19a. Informant's Name/Relationship (Type, Print) David Mackall (Brother	19b. Mailing Address (Street and Number 6111 Burntork Rd.		
fimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	1 X Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, rematory or other place)	Date 20c. Location - City	
tim nit. Pag nartment sortant: nry or o	4 Donation 5 Other Specify: MO 21. Signature of Fundal Service Upensee	unt Carmel Cem. 12 22. Name and Address of Facility	2/02/09 Dundalk Wesley Chavis,Jr	
	Wedley Charts	2007 Eastern A	Ave. Baltimore, M	D 21231
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that cause the death. failure. List only one cause on each line. Immediate Cause (Final disease a, Atherosclerotic Cardiov.)		ic or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of):		
liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clicarca significant Matter)):		
cccuted and transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.):		
be execute ician and urial - tran	UNPENDED AMENDED			
68760, certificate be ending physicial se as the burial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregr	nancy 2 Fetal death 3 Ectopic pre	23d. Date of deliving mancy Month	ery Day Year
ion of Vital Records, P.O. Box 68760, treading Physician: The law requires that the death certificate be executed teath. tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transiation: To Be Completed by Physician/Medical Example.	1 Yes 2 No 9 Unknown Pregnant at time of Unknown	5 Other (Specify)		
P.O. es that the signed by be detach	Part II. Other significant conditions contributing to death but not re Gastric Cancer	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 F	
of Vital Records, and Physician: The law require After this certificate has been significate that the True Be Completed in: To Be Completed			autopsy prior	autopsy findings available o completion of cause of
Rec : The la ificate h r, page	25. Was case referred to medical	26.Place of Death (Che		Yes 2 No
Vital bysician this cert I director	examiner?	[Other =	rsing Home 5 Residence 6 Ot	her:
ion of trending Pheration: After the funeral	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day,Year)	28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
Divis tal or A us after of al Direct lled in by	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At ho	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or or Town, State)	Rural Route Number, City
To the Hospi within 24 hou completely fil	29a. Certifier 1 Certifying Physician: To the best of my knowledge one) Medical Examiner: On the basis of examination a and manner stated			
To To with To com	29b. Signature and title of certifier	29c. License number	29d. Date signed (
1 /	30. Name and address of person who completed cause of death (Item	O.C.M.E.	November 23,	2009
· V	Laron Locke MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2	1201	
State Registrar	31. Date filed Month Day Yesh 32. Registrar's Signatu	refacility		

		For	pe or Print i State of Mary	/land / Dep	artment of H	Health and	-	•	ole.
		1 - State Registrar		Ce	rtificate of	Death		Reg. No. 2 U	09 38092
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Thelma Mille					2. Date of Dea Month	Day 22 7	Year 2:50 P M
Examin	er	4a. Facility Name (If not institution, give str	eet and number)			or Location of Dea	th	4c. County of	
		SEASONS HOSPICE 5. Social Security Number 6. Sex	7 Ago //	n yrs. last birthday	RANDALL If Under 1 Year		8. Date of Birt	BALTI	MORE 9. Birthplace (State or Foreign
Funeral Director			A 2 TOTE	71 Yrs.	Months Days	Hours Min		y, Year)	Country) SC
Maryland I-f show ied at	tor	10a. State 10b. County		C. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
r 28a	Director	10e. Street end Number		SATITIONE	10f. Zip Code			10g. Citizen of W	hat Country?
th wit		4135 ORCHARD RIDGE	BLVD.		21205			USA	
filed within 72 hours after death with the Maryland Hygiene. Hygiene, within "natural", or items 23a or 28a-f show ent, the Madical Examinating the incitied at	by Funeral		Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ANo		Specify Yes or No- to Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. BLACK
permit. Pages 1 and 2 should be filed within 72 hours Department of Heatle and Mental Hygiene Important: If item 27 is marked other than "natural" any Injury or other traumatic event, I'm Medical Ex-	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ion	(Give	edent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Bus	siness/Industry
d with	9	12TH		FO	OD SERVIC	E		CAFET	ERIA
uld be file Aental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last) KENNY WILSON					m <i>e (First, Middl</i> e, LITTLE	Maiden Surname	a)
shot and N s ma		19a. Informant's Name/Relationship (Type	. Print)	19b. Maili	ng Address (Street	and Number or F	lural Route Numbe	er, City or Town, S	State, Zip Code)
and 2 salth 27 I er tra		LESLIE HOWARD/DAUGE	łTER	51	5 CHESTNU	THILL AV	E., BALT	IMORE, M	D 21218
Pages 1 nent of Hi nt: If iten		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State		osition (Name of matory or other pla NITY		Date 10/2009	BALTIMO	Oity or Town, State
permit. Departm Importa any Inju		21. Signature of Funeral Solvice Licensee	r Chan		2. Name and Addre	ess of Facility WE		VIS, JR.	FNRL. HM.
		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final	cause on each line.		ter the mode of dyi	ng, such as cardia	ac or respiratory a		Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a co		dio Jascul	ar DISA	2986		
ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):					
icate be executed physician and s the burial-transit	ical Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of);					
ath certif attending for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□ Ectopic pregnand □ Other <i>(specify)</i> _	су		23d. Date Mor	e of deliv <i>e</i> ry hth Day Year
w requires that the descriptions is been signed by the should be detached	2	Part II. Other significant conditions contri	buting to death but no	ot resulting in the u	underlying cause giv	ven in Part I.			ibute to the ceuse of death? 3 Probably 4 Janknown
sician: The faw requisited that the second inector, page 2 should	Completed							osy p rmed d	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
clan: ertific	Be	25. Was case referred to medical examiner?	***				eath (Check only o	nne)	in-rationt hospi
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ion: To	27. Manyler of Death 1 Natural 5 Pending	apital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day, Ye	2 ER/Outpatie	of 28c. Inju	ry at rk?	Home 5 Residence 1	dence 6 GOthe	er (Specify)
or Attenctifier death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, st Specify)]Yes 2□No	28f. Location (: City or Tox		er or Rural Route Number,
Hospital 4 hours a Funeral tely filled	Medical Ce	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examine one)	r: On the basis of ex	amination and/or is					
the ithin 2 the omple	Med	29b. Signature and title of certifier	and manner stated		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
P. 3 P. 8		· nský opetnem			Do	005746		\ l	122109.
/		30. Name and address of person who com	1D. 25 1	Mainst, S	Print) 414 200	, Reister	stown,	MD. 21	136.
Sta		31. Date filed (Month, Day, Year)	32. Registrar's						
Registr		TEC 0 1 2000	enous A	1					
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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2:45 AM 009 Medical 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 15 County of Death
13 altimore Examiner Kandallstown Kandalls town enesis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. Director 231-36-3219 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9109 Liberty Road 211.33 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: spAfrican-American Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired)
Fivironmental Services e 1 and 2 should be filed within 72 is of Health and Mental Hygiene.
If item 27 is marked other than "nor other traumatic event, the Median Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emest Murphy Bessie V. Jordan 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earlene Gary-Jones/ Guardian 34 Championship Court Owings Mills, MD 21117 Baltimore, : If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Important: If any injury or Mt. Zion cemetery 11-25-09 Lansdowne, MD 21. Signature of Funeral Service License Wlie Funeral Home P.A. of Balto. Co. 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Oneet and Death Vascular Perebral Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death been signed by the s should be detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by thrive Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 뎯 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural injury work? 1 ☐ Yes 2 ☐ No Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier Both a. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHA. WHITEFORD CRNB 6095 MARSHALEE DR, ELKRIDGE MA 32. Registrar's Signature 31. Date filed (Month, Day, Year, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 State of Maryland / 08/05 ment of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 79 Year 2007 **Physician** William Edward Miller Novem /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 9, Birthplace (State or Foreign 5.219-6000 216-60-6000 7. Age (In yrs. last birthday) Funeral Days Maryland 1 🔀 M 2 🗆 F 54 June 10, 1955 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinator must be notified at 1 ☐ Yes 2 ☑ No Director Harford Kingsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21087 United States 2432 Whitt ROad Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ ★○
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 21X10 Specify. Specify:White 2 3 Widowed 4 Divorced Be Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Environmental Company 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F Dorothy Schilling Frank John Miller ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Kingsville, Maryland 21087 Wanda Miller / Wife 2432 Whitt Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 30 1 Deputies 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air, Maryland Bel Air Mem. GArdens 2009 Funeral Service Licenses Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ause on each line. Immediate Cause (Final **♦** Physician Zdays disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Per 08 a attending physician and for use as the burial-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has b , page 2 sl autopsy certificate 2 0 1 ☐Yes 2 ☐ No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 000034406 . Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0053568 November

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

2309

200 robber

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMP SON

Year)

esapeahe

Please Type or Frint in Black indensity amend #20b Per FH G898 12/01/09 TH of Health and Mental Hygiene amend #8 Per FH G899 1/06/10 TH Certificate of Death

Reg. No. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ie Mae 15:30 PM 11 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore GSH Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth 1929 (Month, Day, Tear) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days 212-36-3529 **80**Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ms 23a or 28a-f show MD Baltimore 1 Yes 2 No Funeral Director NIA 10e. Street and Number 10g. Citizen of What Country? 21213 usA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No item 27 is marked other than "natural", or items other traumatic event, the Medical Experience. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature" any injury or other traumatic events. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Be Completed by Specify: 3 Widowed 4 □ Divorced BACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT uspettired)

Core Provider Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ephriam Harrington Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave. Windsor Mill, Mb21244 Walter Moody 3821 Washington 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/03/2009 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Mb Zion Cemaki ion cemery 12 1999 Ballinue Mb 22. Name and Address of Facility Vous Mc. 6 1999 Company 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Seprice Licensee iberty Rd. Randalls town IND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Acute disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 1 Unknown cate has been si page 2 should b Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the tuneral director, page 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mardany MD RES 000 11/25/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buthmore MD Yazdany -5601 21239 Maheli Lock Raven Blv. 82. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Genevieve T. McCarthy 2009 November 27. 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 503 Kintop Rd. Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 217 F 90 215-07-1710 Director 30, 1919 June Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location show 10a State 10b. County s 23a or 28a-f show 1 ☐ Yes 2 X No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 503 Kintop Rd. 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. other traumatic event, the Medical Examiner in should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Maryland 21215-0036 6 1 ☐Yes 2 No þ Yes. Give Specify Specify: 3 ₩ Widowed 4 Divorced Year or Dates: White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Clerk 8 Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Ruszkiewicz ပ Josephine Bystry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Patricia A. Clark / Daughter 503 Kintop Rd., Glen Burnie, Maryland 21061 permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec 1

■ Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 2009 4 □ Donation 3 Offier (Specify) Woodlawn, Maryland Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21. Signature of F MD 21061 23a. Part 1. Enfer the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 34691 mentra /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) death certificate be executed the burial-tran and resulting in death) Last Due to (or as a consequence of) 68760 physician Physician/Medical use as t attending Box IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ó in the past 12 months?
1 ☐ Yes 2 🖺 No 5 Other (specify) signed by the a d be detached for Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy The performed Division of Vital 1 ☐ Yes 2 🖾 No 1 ☐Yes 2 ☐No Physiclan: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation Injury (Month, Day, Year) 1 X Natural To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 22 D20094 November 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliott Gorbady, M.D., 1411 Madison Park Drive, Glen Burnie, Maryland 21061 31. Date filed (Month, Day, Year) Registrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 38097 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 01:40AM Richardine McNeill 2009 17 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Good Samaritan Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F Months Director Nov 22, 1923 So. Carolina 251-32-4922 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examinat must be notified at 1 X Yes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 U.S.A. 1807 Burnwood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 21215-0036 1 ☐Yes 2 ☐No Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Union Memorial Hospital Dietary 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Ivory Parker Kelly Parker P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1807 Burnwood Road Baltimore, Maryland 21239 Cynthia Jamison 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/21/09 Lansdowne, Maryland 4 Donation 5 Dother (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A

23a. Part 1 Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. Immedial Cause (Final disease or condition Approximate Interval Between Onset and Death Myocardial **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Anen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner End Stage Rena attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) s been signed by the a should be detached to Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate has page 2 Division of Vital spital or Attending Physician: Thours after death.
Ineral Director: After this certificat y filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2.☑No Nation 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 17.2009 RESOOD MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DSOUZA, 5601 LOCH RAVEN BLVD, BALTIMORE MD 21239 CAROLINE 31. Date filed (Month, Day, Year) В2. Registrar's Signature State racks Registrar

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND ITEM#6perFH, G898, 12/4/09 WS State of Maryland / Department of Health and Mental Hygiene 38098 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:30P M John Alan McKay 2009 11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium <u>Stella Maris</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM-2 F Months Days Hours Min. (Month, Day, 207-20-7358 Director -6 - 1928Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 6021 Mannington Ave. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. Completed by 1 Never Married 2 Married 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examore. If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Co. Steel Sales Engineer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John McKay Alice Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6021 Mannington Ave., Baltimore, Md. Florence T. McKay/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/28/2009 Baltimore, Md. Parkwood Cemetery 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a Bladder Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performe 1 Yes Be (completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** ည 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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NOVEMBER

JOHIN

TIMONIUM, MD 21093

2/300 DULANEY VALLEY RD.

Registrar's Signature

CRNP

JONES.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 28,2009 **Physician** November 1640 Henry James Mayford, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Havre de Grace Harford Memorial If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 15,1943 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Maryland 1 ₩ 2 □ F 66 219-40-3521 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Department of Heatth and Mental Hygiene. Important: If item 23a or 28a-f shov any Injortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be nother 1 ☐ Yes 2 ☐ No Director Conowingo Md. Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21918 USA 138 Leona Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: <u>ک</u> Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) timore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 12th Computer Programer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental Henry James Mayford Dorothy Cline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Conowingo, Md. 21918 Donata Mayford Spouse 138 Leona Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 12-1-2009 Balto. Md. Bayview 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Solvice Lice Schimunek Funeral Home Nottingham, Md, 21236 9705 Belair Rd. Approximate Interval Between Onset and Death 23a. Part 1 Ænter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the After this certificale has been signed by funeral director, pege 2 should be detach 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Ś 1 🗌 Yes 2 ☐ Probably 4 ☐ Unknown Record Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an death? 1 ☐ Yes 1 □ Yes 2 □ Ho Vital 25. Was case examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To ŏ 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier è

State

31. Date filed (Month, Day,

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Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:40 pM Dorothy Miller 2009 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Towson 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. Country. Director 220-14-1875 83 4 Maryland December Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Baltimore Sparrows Point 1 Yes 2 No 10e, Street and Number 10f. Zin Code ō 10g. Citizen of What Country? Funeral 23a 7417 Chesapeake Ave. 21219 or items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 White 1 ☐ Yes 2x No Specify: "natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 h n and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 8 vears Housewife Own Home injury or other traumatic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Stray Antoinette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Darlene Dillon Daughter 265 Spencer Circle, Forest Hill Md. 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December Baltimore, Maryland Bavview Crematory 2 2009 Ig ture of Funeral Service Lice see 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to for as a consumuence of if any leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ned by the a P.O. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 XNo November 25, 2009 unknow 1 28e. Place of Injury - At home, farm, street, factory, office 1-al Investigation 6 Could not be 4 Homicide building, etc. (Specify) determined Medical Lecturying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated in the cause of the 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
DEC 0 1 2009 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

BALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ McComas Рм James Edward November 2009 6:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death of Death Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs 5. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Country) Maryland 1 🗓 M 2 🗆 F 51 February 14, Director 220-48-1429 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore Monkton Marvland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21111 Funeral J.M. Pearce Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Race - American Indian. Armed Forces Black White etc. Completed by 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Fue1 President Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental I t. Page 1 and 2 should be file tment of Health and Mental I rtant: If item 27 is marked o ည Anne Scarpulla McComas Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J.M. Pearce Road, Monkton, Maryland Emmalee Joanne McComas/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State Service Corp. 12/7/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signatur of Funeral Service Licer 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cancer disease or condition resulting in death) Lung months Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 XN 2 🗆 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HUSOICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

To the I within 2

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

X (harles

Grant

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Towson

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD

2149194

29d. Date signed (Month, Day, Year)

November 30, 2009

O9-09138

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

O9-09138

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		- For State					No. 20	na	38
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)				. Date of Death	100	3. Time	of Death
		Curtis L. Mitchell				November 2	4, 2009	143	9 hrs
be executed permit. Pages 1 and 2 should be filed within 72 hours after death with be executed Department of Health and Menlar Hygiene. Important: If item 27 is marked other than "natural", or items 233 urial - transit injury or other traumatic event, the Medi - I Examiner must be no		4a. Facility Name (if not institution, give street and number	er) 2	4b. City, Town, or Location of Death Baltimore			4c. County of Death		
Comment	-		Tutlon, give street and number? Ab. City, Town, or Location of Death Baltimore Ac. County of Death Accounty of Death						
	John's Hopkins Hospital Baltimore 5. Social Security Number 212-33-2735 6. Sex 7. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 x Yes 2 No 10c. Street and Number 2790 The Alameda 12. Was Decedent Ever in U.S. 13. Was Decedent Hippanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 14. Pes 2 x No specify: Specify: Black 15. Decedent's Education (Specify only highest grade completed) 15a. Dece								
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f Hea					etery,	Date	20c. Location - City	or Town,	State
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical Certification: To Be Completed by Physician/Medical	25. Was case referred to medical examiner? 1	at at time of death 5 0 0 ER/Outpatien FOUND: 1343 hrs of Injury - At home, farm, streeth of the death occurrence occurrence of the death occurrence o	26.Place of the state of the st	of Death (Check of Other) y at Work? y at Work? yes 2 No uilding, etc. te and place, and death occurred a e number M.E.	23e. Did tot 1 Yes 24a. Was a autops perform 1 Yes 28d. Describe h Subject shot 28f. Location (S or Town, St 1401 Carswell due to the cause t the time, date a	Month 2 No 3 24b. Wer y ned? No 1 Residence 6 Ow injury occurred treet and Number of ate) Street, Baltimore 2(s) and manner as and place, and due	Day e to the cau Probably e autopsy f to complet h? Yes Other: r Rural Role e, MD stated. to the caus (Month, Day	use of death' 4 Unkno indings avail ion of cause 2 No ute Number,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Mazer Irene 10:20 PM 11 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE Examiner SEASONS HOSPICE @ NORTH WEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 06-03-1922 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Months 215-14-8446 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov ury or other traumatic event, the Medital Examinant must be notified at 1 ☐ Yes 2 🕱 No Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7932 STEVENSON ROAD 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 □ Yes 2 No Specify by 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KRAMER **JEROME** FELDMAN FANNIE ပ 19a. Informant's Name/Relationship (Type. P. JOAN GURNEY/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 7932 STEVENSON ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUND 11-30-2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage **Physician** ardiomyopath KNO disease or condition resulting in death) /Medical Due to (or as a cons - ence of): Examiner Sequentially list conditions, leave leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Exami ysician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) I Yes 2 □ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 **1** No 24 hours after death.
Funeral Director: After this certific etely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manny of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Watural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

apakse M.D.

iapakse,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

25 Main St.

32. Registrar's Signature

29c. License number

00057465

29d. Date signed (Month, Day, Year)

11/27/09

Reistentown, MD. 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2009 Year Now 28 9:48 \mathbf{A}_{M} Leroy Joseph Nickoles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. 4/7/1940 212-36-2175 Director 69 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll New Windsor 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4027 Franklinville Rd. 21776 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Nickoles & Warner Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 8 Heavy Equipment Operator Excavating Be 17 Father's Name (First Middle Last. 18. Mother's Name (First, Middle, Maiden Surname, ೭ Victor J. Nickoles Mary Elizabeth Luers 1 and 2 should by Health and Meritem 27 is mark 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4134 Alesia Rd., Manchester, MD 21102 Ricky Dean Nickoles/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Conation 5 Other (Specify) Lake View Mem. Park 12/2/2009 Sykesville, MD Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 21. Signa of Funeral Service Licen ert 1. E er the disease, or complications that cau ock, or leart failure. List only one cause of leach ed the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immed, te Cau e (Final disease or condition resulting in death) Physician/ Medical Examiner ension Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran attending physician for use as the buria Physician/Medical certificate be Box 68760 as the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No ed by the a detached f Yes P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, requires Completed 24b. Were autopsy findings available 24a Was an or Attending Physician: The law has prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 I DOA ပ this 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

(Check

only one

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29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type), Prin

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 24 2009 **Physician** ELIZABETH 12:10 November /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltruse Merry Medical N/A | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 57 Director 579-62-9803 Feb 16, 1952 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Examinar nust be notified at 1√2Yes 2 □ No **Funeral Director** N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Modreal Event in the traumatic event in th 21218 3632 Elkader Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes XX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2XXio White þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Veterans Administration Microbiologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Neely Mary Elizabeth Roe ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbi Richardson 17125 Darnestown Road Boyds, MD 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🏋 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/28/09 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Dicense Burgee-Henss-Seit 3637 Falls Road Z Funeral Home Inc. Balto, MD 21211 23a. Part 1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or es e consequence of): Examiner vana Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 moni 1 Yes 2 No 9 Unknown Month Day Year 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 No 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital; Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation eral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifig

Registrar
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32. Registrar's Signatur

ST.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARI

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Month, Day, If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days 1 M 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It with disall Evan in a cust be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 211 00 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 **N**0 Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 3 Removal from State 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) ROGO 21. Signature of Funeral Service Licenses 23a. Part 1. Ensir the disea, e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Divide for as a consequence of Examiner ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No 4 Pregnant at time of death 5 Other (specify) neral Director: After this certificate has been signed by the ifilled in by the funeral director, page 2 should be detached! 9 Unknown 9 Unknown 23e. Did tobaceo use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

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Osles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#23a, pt1, perPHYS, G898, 12/1/09 , WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month reacce 9000 /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner athmore 1050, Ja Secons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** -1939 Hours 1**⊠**M 2□ F Months Days Min Vrs N.C. Director 238-56-4641 70 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 TYes 2 TINO Baltimore N/A Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 2561 W. Lombard Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ∐Yes 2 XNo Specify É 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+h/a filed within Hygiene. Elementary/Secondary (0-12) мта Driver 12th grade marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental I-Minnie Bell High Grady Pearce ဂ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 shi Department of Health and Important: If Item 27 Is m any injury or other traum 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21223 2561 W. Lombard Street Janice Pearce -Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-21-09 Kenly, N.C. Pittman Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H la W MD 21202 an 1101 E. North Avenue Balto, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 20 /Medical Due to (or all a consequence of) **Examiner** Necrotic Bowel Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. attending ph IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) Ö been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ۵, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performer? Yes 2 No page , certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Was case ... examiner? funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA After this Certification: To 28b. Time of 27 Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending М investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: #
filled in by the fu death. 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier License number 31. Date filed (Month, Day 32. Registrars Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOV NOV 2009 12:58PM JOHNNY DEAN POWELL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE STELLA MARIS HOSPICE TIMONIUM Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 17 Birthplace (State or Foreign Country)

FL 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F Hours **Director** 51 217-68-1254 Usual Residence of Decedent 2/ is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 1112 TACE DR USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 🎦 No 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH STORE CLERK GROCERY STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ANITA ANGAS LESTER LEE POWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 1112 TACE DR., BALTIMORE, MD 21221 DEANNA SCOTT/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-30-09 4 Donation 5 Other (Specify) ARDENT HANOVER, MD 21. Signature of Funeral pervice Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease, or co of lications that caus shock, or heart failure. List only ne cause on each eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) LIVER CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of) Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 **K** No 1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Other: မ 1 Tyes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 T Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and 29c. License number 30. Name and address berson who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death NOVEMBER 28 2009 GOLDIE PARKER 802 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BON SECOMS BALTIMO RE HOSPITAZ If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 □ M 2 X F November 27, 1935 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No timer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mondson 2/22 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave daughter 110 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) emeter 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final BRAIN ANOKIC disease or condition resulting in death) Due to (or as a consequence of): ENTRICO LA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

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Physician

/Medical

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Funeral

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72 hours after

Saltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

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Funeral

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the Funeral Director: A mpletely filled in by the fu death.

To the Hospital 5 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) NOVEMBER 29 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dE/AFELD 22 SOUTH C-REENE ST BAZTIMORE MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month Physician 5:00 AM Elva Doris Pepe November 23, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1108 Oak Avenue Baltimore Essex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Min. Days 1 □ M 2 🖫 Hours 87 Yrs. Director 234-32-9561 West Virginia Sep 14, 1922 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Tyes 2 No Director Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 1108 Oak Avenue 21221 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Maryland 21215-0036 1 ∐Yes 2 🛂 No Specify: δ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ... withli. ... wental Hygiene. ... 27 Is marked other than ": y traumatic event Social Security Elementary/Secondary (0-12) College (1-4or 5+) 12 Admin Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Alvin Hauger Lela Taylor ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is n Patricia Wilburn /Daughter 4402 Hooper Avenue Baltimore, MD 21229 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other th once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 24 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 101443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician disease or condition resulting in death) /Medical Due t vovs a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) ad title of certifier 29b. Signature 09 W/> ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Glen 26000 H 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

Registrar

09-0922	29
Joshua	Phillips

ua Phillips		State of Maryland / Departme	ent of Health an ate of Death	d Mental Hy	rgiene Reg. No		09 3811		
Physici ical Exami	an/	1. Decedent's Name (First, Middle,Last) Joshua Eric Dar	niel Phillip	S	2. Date of Death Month Day November 27,		3. Time of Death 1836 hrs		
4		4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	4b. City, Town, or Glen Burnie)		c. County of Deat	el .		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Yea Months Day Yrs.		8. Date of Birth(MM 07/31/2	Fore			
death with the Maryland or items 23a or 28a-f show any must be notified at once,	al Director	10e. Street and Number 224 Pennsylvania Avenue	sadena 10f. Zip Code 211			tizen of What Co	١.		
	ed by Funeral		13. Was Decedent of His If Yes, specify Cubar 1 Yes 2 X No Decedent's Usual Occupa during most of working life	specify:	Rican, etc.) vork done 16b.	White, etc.	white		
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Heath and Mental Hygiene. If Itien 27 is marked other than "natural", other traumatic event, the Medical Examiner	Be Completed	9th 77. Father's Name (First, Middle, Last) Kenneth William	Home Consurname) e Gill	onstruction					
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Datumore, In permit. Pages I and Department of Healt Important: If item injury or other trau	d		ew Crematory	s of Facility Go	nce Funera	1 Servi	e, Maryland ce, P.A. ryland 21225		
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rg Physician: The law require this certificate has been so neral director, page 2 should the	Completed				24a. Was an autopsy performed	prior t death			
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tal or Attendii rs after death. al Director: /	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specific) house	: 18pm farm, street, factory, office	building, etc.	unknown 28f. Location (Stree or Town, State) Pasadena	22/ Pa	Rural Route Number, City		
To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, of investigation, in my opinion	date and place, and n, death occurred	due to the cause(s)	and manner as s	tated. the cause(s)		
iw T	Me	29b. Signature and title of certifier Partill Phurth and Manner stated.	ļ	se number		d. Date signed <i>(I</i> ovember 28,	Month, Day, Year)		
7		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examine	er 111 Penn Stre	et, Baltimore, l	MD 21201				
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ha Nal						

Registrar

09-0921	1
Kenneth	Parka

4a. Facility Name (if not institution, give street and number) Harbor Hospital Center 4b. City, Town, or Location of Death Harbor Hospital Center Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)	neth Parke	1- For State Registrar		rtificate of		na Men		R	eg. No.	201	19 381
The Facility Name of crite installation, give a set and number 40 Cert. Prince of Location 4	Physician/ dical Examiner			tt Parke						Year	3. Time of Death 0617 hrs
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23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	or items 2 must be n Funera	11. Marital Status 1 X Never Married 2 Married	Armed Forces? 1 Yes 2 No	If Ye	es, specify Cuba	an, Mexican	, Puerto R		V	Vhite, etc.	
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	Me R 1 8 1	29b. Signature and title of certifier	1.16						1	- ,	
		7	,	•	n Street, Ba	altimore,	MD 212	201	<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2009 10:30 A M Thomas Rudolph Ricketts, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Gaithersburg 28 Dalmar Street Apt. 1 . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 ☐ F Days Hours 05/06/1938 Director 218-34-5790 MD. Usual Residence of Decedent show 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director Gaithersburg MD. Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20877 28 Dalmar Street Apt. 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Armed Yes 2 No Vietnam Black, White, etc. 1 🛂 Never Married 2 🗌 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates. Korea Completed ind Mental Hygiene.
s marked other than "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry grade completed) (Specify only highest Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dorothy Levinia Watkins Thomas R. Ricketts, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Dalmar Street Apt. 1 Gaithersburg, Md. Charles Ricketts/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/02/2009 Carroll Crematory Winfield, MD. 21. Signature of Europe 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 West Old Liberty Road Winfield, MD. Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Priysician end years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or linjury 24 hours after death.
24 hours after death.
25 Fineral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 1 🗌 Yes ٥ 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Bural Boute Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospital within 24 hor To the Fune completed fi

> State Registra

only one) 29b. Signature and title of certifier

ama

Shama Mittal, M.D. 31. Date filed (Month, Day, Year,

DEC 0 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14816 Physicians Lane, Suite 152 Rockville, MD. 20850 32. Registrar's S

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

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		1 - For State Registrar		epartment of Certificate o		R	eg. No.	
Physic /Med Exam	ical	1. Decedent's Name (First, Middle, Las 4a. Facility Name (If not institution, give	rick RILL	4b. City, Town,	or Location of Death	2. Date of Deat Month	Day Year 78 2009 4c. County of Deatl	3. Time of Death
Funera Directo		5. Social Security Number 6. S 319-52-370-4 1 Usual Residence of Decedent	7.6000	rs. If Under 1 Years. Months Day		8. Date of Birth	Year) 9. Birth Con 1949 Man	hplace (State of Foreign untry)
e Maryland ka-f show	Director	10a. State 10b. Gounty	10c. City, Town	or Location Thinsto				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with th	ral Dire	10e. Street and Number 751 Quartz	. D.	10f. Zip Code 2/15	8	1	0g. Citizen of What Co	
-UU36 hours after death with the Maryland tural", or Items 23a or 28a-f show at East, in comust be motified at	by Funeral	11. Marital Status 1 ■ Never Married 2 ■ Married 3 ■ Widowed 4 ■ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of If Yes, specify Co	of Hispanic Origin? (Suban, Mexican, Puert Suban, Mexican, Puert Suban, Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	rican Indian, a, etc.
vithin 72 ene.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		Decedent's Usual Occ Give kind of work dor life. DO NOT use reti	ne during most of wor ired)		16b. Kind of Business/	Industry
Maryland 2 d 2 should be filed tht and Mental Hygi ? Is marked other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last)	vis Rill		18. Mother's Nan	ne (Firgt, Middle, I	Maiden Sprname)	he-
e, Maryl 1 and 2 shoul Health and M em 27 Is mar		19a. Mormant's Name/Relationship (- Flagat 14	06 Weldo	n Place	NO41	r, City or Town, State, 2	M. 21211
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 2)	Removal from State	Disposition (Name of crematory or other p	tory 10-	1-09	20cs Location - City or	Town, State
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→ Physiciar	1	23a. Part 1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death. Do not cause on each line.	ot enter the mode of o	dying, such as cardiad	or respiratory arr	est,	Approximate Interval Between Onset and Death
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VItal Records, P. O stclan: The law requires that the certificate has been signed by th irector, page 2 should be detache	Completed					24a. Was a autopoperfor 1 □Yes	sy prior to med? death?	utopsy findings available completion of cause of 2 No
of Vital F Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor:	ath (Check only or		
Phy rathis	<u>ان</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. T	patient 3 DOA	4 LI Nursing F		ence 6 Other (Spe ow injury occurred	ecify)
Attending death. ctor: Afte	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	(Month, Day, Year) Ir	ijury V M 1	njury at Vork? I∐Yes 2∐No ce		treet and Number or Ri	ural Route Number,
To the Hospital or within 24 hours after To the Funeral Direction completely filled in biggins.	Medical Cer	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Example	ysician: To the best of my knowledge niner: On the basis of examination and and manner stated.	, death occurred at th d/or investigation, in n	e time, date and plac ny opinion, death occ	e, and due to the ourred at the time, o	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
Vithin 2 the comple	Med	29b. Signature and title of cartifier	and mailler stated.	29c. Lic	ense number	2	29d. Date signed (Mont	th, Day, Year)
6348		Day Pata		1013	142983		11-30-2	.009
,	, U	30. Name and address of person who	completed cause of death (Item 23a) (Type, Print) 5 Gpeen	y St I	alt mo	ec, MD	2/201
Pogis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	male I				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** WILLIAM A. REILEY 1:30 P November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A FutureCare of Charles Village Baltimore 3 8 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months 1 € M 2 □ F Days Min Hours 219-32-7825 Director May 28, 1936 Maryland | Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f show event, the "hadical Examinar in ust be notified at N/A Director Maryland Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 Park Avenue, Apt. 1206 USA 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore 12 The City Collector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Albert E. Reilev Sr. Loretta A. Myers ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 1443 Riverside Avenue, Baltimore, Maryland 21230 (Cousin) 27 Margaret A. Reiley item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or once. Loudon Park Masoleum Nov. 25, 2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) Signature of Funeral Service Licen Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 Fast Fort Avenue, Baltimore, Maryland 21230 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** lanew months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** dryswhim kay Sequentially list conditions, if any, leading to immediate and Entry Cause (Disease or injury Due to (or as a consequ Physician/Medical Examiner The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) hed 1 ☐Yes 2 ☐ No. 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 【No 24a. Was an has autopsy page ; perform After this certificate 1 ☐ Yes 2 **X**No Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes the after death 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number DON NOVEMBER 24,2009 0 57088 Caru # 60 Bartimore, MI) 21202 601, 30 31. Date filed (Month, 32. Re State Registrar

			for State of N State of N Registrar	/laryland		artment of F <i>tificate of L</i>		d Mental Hy	giene Reg. No. 2	009	38118
	Physicia	ın/	Decedent's Name (First, Middle, Last) Samuel Richardson				_	2. Date of De	ath Day	Year	3. Time of Death
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اسر	Funeral		5. Social Security Number 6. Sex 7. A	Lal Age (In yrs. Ia.	st birthday)	_lf Under 1 Year	imore		th	9. Birth	place (State or Foreign
	Director		170=36-7039 1X M 2 ☐ F Usual Residence of Decedent	5	3 Yrs.	Months Days	Hours Mi	Juli 23	, 1946	Coul	PA
	aryland a-f sho fied at	Director	10a. State 10b. County MD		, Town or Lo						10d. Inside City Limits 1 Yes 2 □ No
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, Mar	id 2 shou salth and n 27 is n er traum		19a. Informant's Name/Relationship (Type, Print) Karin Blakemore	19b. Mailing Address (Stre 207 Woodla			nd Number or F	Rural Route Numbe Baltimo:	r, City or Town	n, State, Zip 2121	Code) 0
Baltimore, Maryland 21215-0036	age 1 ar ent of He nt: If iten y or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ other (Specify)	е се	emetery, cren	sition (Name of natory or other place	· !	Date		on ~ City or To	
Baltii	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of June 1 Strick in see	1	22	M. Park Name and Addres	s of Facility W	/27/09 esley Cl	havis	lawn, Jr.	FH
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. Box 68	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours deter death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	2 Fetal at time of de	death 3	Ectopic pregnancy Other (specify)	/			Date of deliv Month	ery Day Year
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Division of Vital Records,	The law recate has be page 2 sho	Completed						24a. Was a autop perfor	sy med2	b. Were auto prior to co death? 1 \(\sum \text{Yes}	psy findings available mpletion of cause of
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visior	or Attending Physician: The karafer death. Director: After this certificate ha lin by the funeral director, page	Certificate:	✓ Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of In building, et	jury - At hom tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office	/es 2 ☐ No	28f. Location (S. City or Town		nber or Rural	Route Number,
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:	To the I within 2 To the I comple:		only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	best of my k	knowledge, d	eath occurred at the 29c. License	time, date and p	place, and due to the	cause(s) and 29d. Date sign	manner as st	ated.
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	かり		30. Name and address of person who completed cause of a	Doior	m c	int)	1 Hos	pital T	36 140	nure,	am
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Physician /Medical Examiner

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

Pages 1

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funeral After t ospital or Attending hours after death. n 24 hours after אינים the Funeral Director: Af Hospital within 24

Division or Vital Records, P.O. Box 68760,

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Medical

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arthur Schoengold, M.D. 18111 Prince Philip Dr., Suite T-10, Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature

UEL () 1 ZUUS

5 Pending

Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

investigation

6 Could not be determined



and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)



1 ☐ Yes 2 ☐ No

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D 18726

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) November 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	01010 0111	iai yiaiii		rtificate of	Death	vicinal riyg	Reg. No. 200	9 38120	
	Physici	an	1. Decedent's Name (First, Middle				·		2. Date of Dea	ıth	3 Time of Death	
1000	/Medic	cal	Diana Sue Ru							er 9, 2009		
	Examir	ner	4a. Facility Name (If not institution Mandrin Hosp	_	7)		4b. City, Town, o	or Location of Death	1	4c. County of D		
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)	
	Director		578-56-5941	1 □ M 2 🖾 F	68	Yrs.	Months Days	Hours Min.	Aug 1,		shington, DC	
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation				10d. Inside City Limits	
	a-fsh	tor	MD Anne A	runde1	Lo	othian					1 ∐Yes 2X∑No	
	or 28	Director	10e. Street and Number		-		10f. Zip Code		1	10g. Citizen of What	Country?	
	s 23a	eral	5600 Bounty's C				20711			USA		
"	fter de ritem iner	Funeral	11. Marital Status 1 □ Never Married 2 Marri	12. Was Decedent Armed Forces' ied 1 □Yes 2X	?	3. 13. V	Vas Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	14. Race - A Black, W	American Indian, /hite, etc.		
93	ral", o	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□Yes 2⊠No	Specify:		Specify:	white	
<u>ئ</u>	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exeminat must be redified at	Completed	15. Decedent (Specify only highes	's Education It grade completed)	- 14	16a. Deced	lent's Usual Occu kind of work done	pation during most of work d)	king	16b. Kind of Busine	ess/Industry unit	
72	within iene. than	duc	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use retire					
b D	al Hyg other	Be C	17. Father's Name (First, Middle, I	<u> </u>					e (First, Middle, i	Maiden Surname)		
ylaı	should be f and Mental s marked o	2	David Galvin					Rose Gal	Lvin			
Baltimore, Maryland 21215-0036	tra = 1		19a. Informant's Name/Relationsh Louis Rubin/spo			19b. Mailin	g Address <i>(Street</i>	and Number or Ru.	ral Route Numbe	r, City or Town, Stat Maryland	te, Zip Code) 20711	
ē,	1 an Hear Sm 2	1	20a. Method of Disposition					<u> </u>		20c. Location - City		
E O			1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other Sp		ce	metery, crem	sition (Name of natory or other pla	ce)			or rown, class	
a	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	// // //	ector	\$22. \$1	Name and Addre	ess of Facility Omy Board	1: 655 W	. Baltimo	re Street	
<u> </u>	90 E 8 9	0. 9	1 mm/	11/100		Ва	ltimore,	Maryland	1 21201		re bereet	
			23a. Part 1. Enter the disease or shock, or heart failure. List of	only one cause on each I	ine.			ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death	
ine.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Brain		etasti	se s				5 months	
	Examiner			Due to (or as	a conseque	ence orj:						
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.)	Due to (or as	a conseque	ence of):					II.	
	and and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):						
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8	= 5 6	Medical	IF FEMALE:	u.	·							
X P Q	death cer		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal of	death 3 🗌	Ectopic pregnance	ey .		23d. Date of		
	the de y the a	Physician/	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of de	ath 5□	Other (specify) _			Month	Day Year	
ν. T	s that med b e deta	by Ph	Part II. Other significant condition	ns contributing to death t	out not result	ting in the un	derlying cause giv	en in Part I.	23e. Did tot	pacco use contribute	e to the cause of death?	
Records,	equire en sig ould b	led b							1 □ Y€	es 2□No 3□	Probably 4D Unknown	
ပ္တဲ့ မ	has be	Completed							24a. Was a		autopsy findings available to completion of cause of	
<u></u>	n: The ficate r, pag								perforr	neg? death	n? ∕es 2 □ No	
VItal	rsicial s certii lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	4 005	D/O-44	3 DOA Oth	26. Place of Deat		/	macify 10501 Ce	
ם ר	ig Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Inju		R/Outpatient 28b. Time of Injury	28c. Injur	4 LI Nursing Ho		ence 6 🗹 Other (S ow injury occurred	Specify)	
SION	eath. or: Af the fur	catio	1 Natural 5 Pending 2 Accident investiga	ation	iy, rear)	піјагу		Yes 2 □ No				
<u> </u>	or At after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 28e. Place of inj	ury - At hom c. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,	
	=		29a. Certifier 1 Certifying	Physician: To the best	of my know	ledge, death	occurred at the ti	me, date and place,	and due to the c	ause(s) and manne	r as stated.	
	in 24 l	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examinatio	on and/or inve	estigation, in my o	pinion, death occur	red at the time, d	ate and place, and o	due to the cause(s)	
ı	Zon With	Σ	29b, Signature and the of certifier	V			29c. Licens	e number	2	9d. Date signed (Mo	onth, Day, Year)	
		1	30 Nom and address (Mo	Joseph //s	20-) /T : =		UTL		11/11/19		
			30. Name and address of person w	Completed cause of c	. (2	Stak	(/	Suite 3	300 C	200.00	MO 21411	
	Stat	~	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu		And I	<u> </u>		WI III V		
	Registra	r	DEC 0 1 20	149 Sentua	1 1.	par						

		end #13,14,15,1 1- For State Registrar	ease Type o 6a,17,17, State	r Print in 196,20a of Marylar		delible 22 pe artment tificate			and i	All Copie Mental H		00	ole.	
Physicia /Medic	an	1. Decedent's Name (First, Middle MIGUEL				DRIC	NE:	ک		2. Date of D Month	RER I	ر ک ام	19 Year ∞9	38 2 3. Time of Death 2235 M
Examin		4a. Facility Name (If not institutio The Johns Hopkin 5. Social Security Number unk	s Hospital	mber) 7. Age (In yrs.	last hirthday)	4b. City, T Baltin If Under	nore			8. Date of B	В	c. County o	ore	ace (State or Foreign
Funeral Director		Usual Residence of Decedent	1 ∑ M 2□F	46	Yrs.	Months	Days	Hours	Min.	April	av. Year	1963	Mexi	
the Marylar 28a-f show otified at	Director	MD Balt 10e. Street and Number unk	imore		ty, Town or Lo	2	2	ın İr			1.40- 0	141 F N# (I)		d. Inside City Limits 1 🛣 Yes 2 🗌 No
must be n	Funeral Di	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.	10f. Zip-0			igin? (Sr	pecify Yes or N Rican, etc.)	Mex	itizen of Wh		
72 hours after death with the Maryland natural", or items 23a or 28a-f show lical Examiner must be notified at	þ	1 Never Married 2 🔀 Mar 3 Nidowed 4 Divorced	If Yes Gi	2 🔀 No ve		1 🔀 Yes 2	□No	Specify.		Rican, etc.)			White, et	· White
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	To Be Co	17. Father's Name (First, Middle, Eceuuiel Rodri	•	uiel Ro				18. Moth	er's Nan	ne (First, Midd	, Middle, Maiden Surname)			
nd 2 shatth and 27 is m		19a. Informant's Name/Relations Jose Rodriguez		_	1201	Steel Steel	ton pone	and Numb	2 , 2 r	ral Route Num	Ba1	timor	e, M	D 21224
t. Page rtment c rtant: If		20a. Method of Disposition 1	in et	State Mui	Place of Disponding Place of Disponding Place of Disponding Control of the Contro	Cente EI 0	real	of hal 1	2/12	Date 2/2009	Pue	ocation - C	Mexi	
permi Depa Impo any Ir		21. Signal re uneral equica OTI	1180		-	laltin	And ore	. Mar	Vla:	d, 655	ı Sil	Dalti	more ring,	MD 20910 Approximate
Physician /Medical		shock or heart failure. List Immediate as se (Final disease or condition resulting in death)	a. LIVES	each line. DISCASI (or as a conseq	_									nterval Between Onset and Death
be executed sician and purial-transit	amir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a conseq						•				
cate be e physician s the buris	edical		d											
death e atter ed for		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	tcome of pregna birth 2 Teta nant at time of d nown	al death 3	Ectopic pre Other (spe						23d. Date Mont		/ day Year
es tha	þ	Part II. Other significant condition	ons contributing to o	death but not res	sulting in the u	inderlying ca	ause giv	en in Part	I.					cause of death?
The ate has page	Completed									24a. Was auto perf 1 Yes		✓ pri	or to com ath?	sy findings available pletion of cause of
his ce	P B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1		ER/Outpatien			r: 4□Nu		me 5 Res	idence			
ling Ing After fune	ertification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	gation	of injury th, Day Year)	28b. Time of Injury	м		at ? es 2 🗆	No	28d. Describe				Route Number,
To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	OF	4 Homicide determ		ing, etc. (Specif)	()			e. date ar	nd place.	City or To	wn, State	9)		
the Hospital of thin 24 hours a the Funeral Dimpletely filled	edica	one) 2 Medical	Examiner: On the band man	easis of examina ner stated.	tion and/or inv	estigation, i	in my op	oinion, dea	ath occur	rred at the time	e, date a	nd place, ar	nd due to	the cause(s)
Neith Con	≥	29b. Signature and title of certifier	7				License	number				ate signed (Month, Da	2009
		30. Name and address of person DOMINIC PAPA 31. Date filed/Meath Day Yearth	who completed cau	se of death (Iter	n 23a) (Type,	Print)			600 l	North W	olfe S	St, Balt	imore	, MD, 2128

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 B **Physician** 2009 10pm M Edna Roeth NOV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lutheran Home Woodlawn
If Under 1 Year | If Under 24 Hrs. Augsburg Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2**X** F 90 1919 Maryland Director Feb. 1, 212-05-8100 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Cockeysville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21030 USA 13 Warren Common Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify White þ 3 X Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be file tment of Health and Mental H tant: If Item 27 is marked oth Emma Kraft မ Edward Huber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cockeysville, MD 21030 13 Warren Common Milton R. Roeth, Jr./Son Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial
Park Cemetery Date 2, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any Injury or 2009 Glen Burnie, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
Flagle | 10 W. Padonia Road Timonium, MD 21093 Signature of Funeral Ge Michael J. Palt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia End Stade disease or condition resulting in death) /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner O. Box 68760, attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the a detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use Antribute to the cause of death? ρ of Vital Records, 2 No 3 Probably 4 Unknown s been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 M No 2 🗆 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2XNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

Kathy Dai 31. Date filed (Month, Day, Year)

CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25 Main

St

Ste 200

DHMH 17 Rev 1/2001

29c. License number R144682

Reisterstown, MD

29d. Date signed (Month, Day, Year)

NOV 30 2009

21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar		Giaio Gi	iviai yiai		rtificate of L		Wierital Try	Reg. No.	2009	38123
	Physici	an	1. Decedent's Name						-	2. Date of De Month	Day	/ Year	3. Time of Death
	/Medi		Willia		John		F	ossi Jr		Novemb	er 2	9, 2009	4:21 a ^M
	Examir	ier	4a. Facility Name (If r					4b. City, Town, or		th	4c.	County of Death	
	Funeral	-	Upper Che 5. Social Security Nur			Cente		If Under 1 Year	Bel Air If Under 24 Hrs	8. Date of Bir	rth	Harford 9. Birtho	lace (State or Foreign
	Director		218-58-74	425 ¹³	∑ M 2□ F		8 Yrs.	Months Days	Hours Min	8. Date of Bir (Month, Da Novemb	er 1.		lace (State or Foreign try) Maryland
	death with the Maryland ms 23a or 28a-f show	tor	10a. State 1	10b. County Hari	ford	10c. Cit	y, Town or Lo	cation Bel A	ir			10	0d. Inside City Limits 1 ☐ Yes 2√ No
	r 28a	Director	10e. Street and Numb	per				10f. Zip Code			10g. Citi	izen of What Coun	itry?
	th with	<u>a</u>	1135 St	tarmount	Court				21015			USA	
	r dear	Funeral	11. Marital Status		12. Was Decede Armed Force		S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify Yes or No)-	14. Race - America Black, White, e	
ر / 036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturaly," or items 23a or 28a-f show any injury or other traumatic event, the Machael Exercitive Intelliged at once.	ģ	1 ☐ Never Married 3 ☐ Widowed 4		1 Yes 2 If Yes, Give Year or Date	□No		_	Specify:	10 / 110411, 0.0.7		Specify: Whi	
12 J	72 hc	etec	(Specify	5. Decedent's Edi	ucation de completed)		16a. Dece	dent's Usual Occupa	ation Juring most of wo	orkina	16b. Ki	nd of Business/Ind	dustry
0 42 l 21215-0036	filed within Hygiene. Ither than tent, the feat, the fea	Completed	Elementary/Second	lary (0-12)	College (1-4	or 5+)	`life.	kind of work done of DO NOT use retired Supervi			C	hemical (Company
nd	be file tal Hy d oth	Be	17. Father's Name (F)					•	18. Mother's Na	me (First, Middle	, Maiden	Surname)	
yla	should I	To	William .			_				nor H. K			
/ O	d 2 sh th and 7 Is n traun		19a. Informant's Nam Eleanor I		iype. Print) Mot	hor		ng Address (Street &					Code)
e 9	1 and Heal tem 2		20a. Method of Dispos		PIOL			O Queensw sition (Name of natory or other place				Cation - City or To	wn. State
/ S	Pages ent of nt: If I			Cremation 3 ☐ ☐ Other (Specify		ile		natory or other place .dge Cem.	;	ember 2009	Hale	ethorpe,	Maryland
11/29/09 Baltimore, Maryland	permit. F Departm Importar any injur		21. Signature of Fund			110		2. Name and Addres	s of Facility				1
<u>m</u>	9 9 E 29	4 3		~. X	~			Connelly 7110 Soll	Funeral ers Poi	Home Of nt Road.	Dung	dalk, P.A dalk, Md	A. 21222
# 288518 68760,	Physician //Medical By a physician and as the privile-transit as the burial-transit	Medical Examiner	Immediate Cause (Fi disease or condition resulting in death) Sequentially list condition cause. Enter Underly Cause (Disease or in that initiated events resulting in death) Last		Approximate Interval Between Onset and Death								
O. Box	Hospital or Attending Physician: The law requires that the death certific 24 hours after death. Funeral Director: After this certificate has been signed by the attending I tely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 N 9 Unknown	onths?		h 2□Feta nt at time of d	I death 3	Ectopic pregnancy Other (specify)	,		2	23d. Date of delive Month	ery Day Year
S, P.	es thal igned l		Part II. Other significa	ant conditions co	' '	h but not resu	ulting in the u	nderlying cause give	n in Part I.	- 1			e cause of death?
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WILLIA!	ding Physician: The law n. After this certificate has b funeral director, page 2 st	Completed by	loca	mont	LS	chen	e	Attack	<u></u>	24a. Was auto perfo 1 □ Yes		prior to cor death?	psy findings available inpletion of cause of
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j. j	Physi this c	P.	1 ☐ Yes 2 ☑ No			atient 2 💢			4 L Nursing I	1		6 ☐Other (Specify	y)
	ding l	ion		5 Pending	28a. Date of (Month,	Day, Year)	28b. Time o Injury	Work	?	28d. Describe	how injury	y occurred	
R055 Division	Atten death ctor: y the	ficat		investigation 6 Could not be determined	28e. Place of	Injury - At ho	me, farm, str		∕es 2□No	28f. Location (Street and	d Number or Rura	l Route Number
≪ ÿ	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fun	Certification:	4 Homicide		10.			eet, factory, office		City or To	wn, State)		
	n 24 ho	Medical	29a. Certifier 1 (Check only 2 one)	Medical Exam	sician: To the be iner: On the basi and manner	s of examina	wledge, deat tion and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) date and) and manner as si I place, and due to	tated. the cause(s)
	To the vithing to the complete	ž	29b. Signature and titl	of certifier	1	-//	1	29c. License		_	29d. Date	e signed (Month, L	
			1/4	3	0	Ch		1)uc	0572	23	11	170/20	∂Ϋ́
	12V		30. Name and address	s of person who co	ompleted cause of	of death (Item	23a) (Type,	erint) ake Driv	a Rai	nic 1110	21/	2111	
	Sta	te	31. Date filed (Month,	Day, Year)	32. Reg	strar's Signal	ture	ARE UTIV	C DU	MII, MI	216	717	·

Registrar

DHMH 17 Rev 1/2001

State Registrar (Check only one)

29b Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 01

Cheryl A. Aylesworth,

M.D., 2730 University Bl., West, #400, Wheaton, MD 20902 egistrar's Signatur

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D54378

29d. Date signed (Month, Day, Year)

11/30/2009

		•	FOR State Registrar	,	Cert	ificate of E	Death	Re	g. No.	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Medic	al	Mark A. Smith, 4a. Facility Name (if not institution, give street and numl			Ab City Town or	Location of Doub	November		
	Examin	er	1065 Loving Road	61)		_	Location of Death		4c. County of Dea	rundel Co.
	Funeral Director			7. Age (In yrs. last b	oirthday) Yrs.	Months Days	If Under 24 H <i>r</i> s. Hours Min.	8. Date of Birth (Month, Pay, Y	9. Bir 951	thplace (State or Foreign untry) MD
	nd now	١	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	ation				10d. Inside City Limits
	lanylar 3a-f sl iffed	ectc	MD Anne Arundel		evern					1 🗌 Yes 2 🔯 No
	the N	١	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	h with	Funeral Director	1065 Loving Road			21144			U.S.A	Α
	r deat or iten		11. Marital Status 1 Never Married 2 Married 12. Was Deceded Armed Ford 1 Yes	ent Ever in U.S. ces?	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
50	rs afte ral", c Exam	q pa	3 Widowed 4 Divorced If Yes, Give		1	☐ Yes 2X No	Specify:		Specify: W	nite
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed)	16	6a. Decede	ent's Usual Occupa	ation Juring most of worki	na 10	6b. Kind of Business	Industry
72	ithin 7 ene. r than	Com	Elementary/Seconday (0-12) College (1-4	or 5+)		NOT use retired)	ian		Constr	cuction
פַ	illed w Il Hygi I other	Be	17. Father's Name (First, Middle, Last)			11600110		e (First, Middle, Ma		decion
ylar		욘	Leo Smith				Mildre	d M.	Blankr	ner
		ij	19a. Informant's Name/Relationship (Type, Print)	11	-				ity or Town, State, Zi	•
e,	and 2 Health tem 27 other tr		Mrs. Janet Smith / Wife 20a. Method of Disposition	20b. Plac∈		55 Loving			MD 21144 0c. Location - City or	
ē	Page 1 ient of nt: If i		1 Burial 2 Cremation 3 Removal from 5 Under (Specify)	State ceme	tery, cremi	atory or other place	e) ark 12-0		Glen Burn	
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		21. Signature of Funeral Service Econsee	W)//>	22.	Name and Addres	ss of Facility 1	2nd Avenu	ie SW Gle	n Burnie, MD
		- 1	23a. Part 1. Enter the disease, or complications that ca		•				ion Serví	Approximate
~	Physician/		shock, or heart failure. List only one cause on eac Immediate Cause (Final disease or condition	n line.	5000	intin h	and a	LOVED		Interval Between Onset and Death
	Medical		resulting in death)	r as a consequenc	e of):	40 (1C)	coru p	ter		
	Examiner	<u>.</u>	Sequentially list conditions, b.							
	ed	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury	nas a consequenc	e of j					
D	xecut n and al-trar		that initiated events C.	r as a consequence	e of):					
20	ificate be executed g physician and as the burial-transit	Medical	d							
09/89	ertifica Jing pl		IF FEMALE:	ome of pregnancy						
POX I	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd eath. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	in the past 12 months?	irth 2 D Fetal dea ant at time of death		Ectopic pregnanc Other (specify)	У		23d. Date of de Month	Day Year
7. O	that the ned by detact	by Pł	Part II. Other significant conditions contributing to de	ath but not resultin	g in the un	derlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	quires en sig ould be	ted t						1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown
Records,	The law re ate has be page 2 sho	Completed				 		24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
VItal	ician: Sertific ector,	Be	25. Was case referred to medical examiner? 1			26. Pla	ace of Death (Check	only one)		
O T O	r this eral dir	e: 10	27. Manner of Death 28a. Date of		Outpatient Time of	3 DOA Oure	4 L Nursing Ho	me 5 Residence 28d. Describe how	injury occurred	cify)
0	ath. ath. r: Afte	icat	2 Accident Investigation	, Day, Year)	injury	M 1 🗆			,,	
DIVISION	I or Atte after de Directo	Certificate:		of Injury - At home, g, etc. (Specify)	farm, stree	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
_	Hospita 24 hours Funeral eted filler	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis	of examination and	d/or investi	gation, in my opinio	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	To the within To the Comple	Σ	only one) 3 Ucertifying Nurse Practioner: To 29b. Signature and title of certifier	the best of my kno	owledge, de	00- 1:00-0			1.01	(D \(\(\)
			> the Villan	My		(V	14715}	IN	svaulou.	30,2009
	4		30. Name and address of person who completed cause PETER PLAMIREZ W	of death (Item 23a	a) (Type, Pr	int) vel 6	Pen Bun	e Not	21061	70, 2009
	Stat Registra		31. Date filed (Month, Day, Year) 2009 32 Re	gistrar's Signature	1890	(Notes				

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 38128 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year 9:50 AM CLARENCE SMITH 2009 NUVEMBER 21

4b. City, Town, or Location of Death

Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Baltimore City

10f. Zip-Code

1 Yes 2 No

21224

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Age (In yrs. last birthday)

10c. City, Town or Location

BALTIMORE

63

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates:

College (1-4 or 5+)

1 🔀 M 2 🗆 F

10b. County

15. Decedent's Education (Specify only highest grade completed) 4c. County of Death

10g. Citizen of What Country?

Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

600 North Wolfe St, Baltimore, MD, 21287

USA

8. Date of Birth (Month, Day, Year) JAN. 31,

Birthplace (State or Foreign Country)

WV

10d. Inside City Limits

1 Yes 2 No

Physician /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital Social Security Number **Funeral** Director 212-50-1555 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or 28a-f show items 23a or 28a-f sho ner must be notified at Director MD 10e. Street and Number Funeral 223 S. COLLINGTON AVE. 11. Marital Status 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 à 3 Widowed 4 Divorced pleted ! Elementary/Secondary (0-12) Department of Health a Important: If item 27 is any Injury or other trainonce. **Physician**

/Medical **Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending PhysIclan; The law requires that the death certificate be executed within 24 hours a

To the Funeral C

completely filled

> KARTINK 31. Date filed (Month, Day, Year)

COL	12TH		LINEMA	N			ELECTRIC	POWER
Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Maid	len Surname)	
0	CLEAVE SMITH				EDITH			
	19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailing Add	Iress (Street	and Number or Ru	ural Route Number, Cit	y or Town, State, 2	ip Code)
	ANNA MARIE SMITH	/WIFE	501 N.	EAST	AVE., BA	LTIMORE, M	ID .	
	20a. Method of Disposition		ace of Disposition metery, crematory				Location - City or	Town, State
	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	I tellioval ilolli otate	ent Crei		11-2	3-09 Ha	norrow M	D
	21. Signature of Funeral Service Ligans				y of Eacility 7-7 -	-la-cha	nover, M	ט
	lole.					sley Cha		
	0	1 comple.				e. Balti	more, MD	
	23a. Part 1. Enter the disease, or comp		Do not enter the	mode of dyi	ng, such as cardia	or respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final	a GASTROINTEST	TINAT BI	EEDIA			- 1	Onset and Death
	disease or condition resulting in death)	a. Due to (or as a conseque		CCDIII	4			
	4	200 10 (01 00 0 00100000	3,100 0.7.					
ē	Sequentially list conditions,	b Due to (or as a conseque	ance of):					
Ě	if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	Due to (or as a conseque	erice oi).					
xan	that initiated events	c						
ω —	resulting in death) Last	Due to (or as a conseque	ence of):					
edical		d						
eq							1	
hysician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan					23d. Date of del	ivery
<u> </u>	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of dea		oic pregnanc r <i>(sp</i> ec <i>ify)</i>	Y		Month	Day Year
S	1 Yes 2 No 9 Unknown	9 Unknown		,,,,_				
_	Part II. Other significant conditions of	ontributing to death but not resu	iting in the underly	ring cause g	iven in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
ò						1 ☐ Yes	21 No 3 Pr	obably 4 Unknown
Completed						1	24,10	
be						24a. Was an autopsy	prior to	topsy findings available completion of cause of
E						performed	death?	
Č	25. Was case referred to medical				26 Place of Dea	th (Check only one)		
Ď	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 E	B/Outpationt 3	DOA Oth		ome 5 Residence	6 Other (Spec	264
2	27. Manner of Death		R/Outpatient 3 2 28b. Time of	28c. Injui		28d. Describe how in		any)
Ö	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k?	25d. Describe flow if	gary occurred	
cation:	2 Accident investigation		М		Yes 2 No			
Ĕ	3 Suicide 6 Could not be determined	 28e. Place of injury - At hon building, etc. (Specify) 	ne, farm, street, fac	ctory, office		28f, Location (Street City or Town, Sta		ural Route Number,
Certifi		3,						
cai		ysician: To the best of my know						
Ö	(check only 2 Medical Exam	miner: On the basis of examination and manner stated.	on and/or investiga	ation, in my	opinion, death occ	urred at the time, date	and place, and du	e to the cause(s)
Medi	29b. Signature and title of certifier	1		29c. Licens	e number	29d. I	Date signed (Mont	h, Day, Year)
	De 26 11	MD		DES	000	4.10	VEM BEN	21, 2009
	MUNICI			~63		1/20	, C1 0 1.1C	-1, 1
	20 Name and address of nerenn who	completed cause of death (Item	23a) (Type Print)					

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edna Marie Smith Physician/ Month 2009 7:50 P[™] Medical Novembe 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Heritage Nursing Home Dunda1k Baltimore Co. Social Security Number 8. Date of Birth (Month, Day, Aug. 2 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 St F Director 214-22-2968 83 Virginia Usual Residence of Decedent ıral", or items 23a or 28a-f shov I Examiner must be notifled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Edgemere Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 United States 7323 Hughes Avenue 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1 Never Married 2 Married "natural", or Maryland 21215-0036 ☐ Yes 2 🙀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify. Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Years injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy Deale Nora Flippo permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7323 Hughes Ave. Edgemere, Maryland 21219 19a. Informant's Name/Relationship (Type, Print) Mrs. Patricia Baker (Daughter) Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 12/1/2009 Baltimore, Maryland ure of Funeral Service Licensee Duda-Ruck funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) detached 9 Unknown P.O. þ signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 δ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform 1 Yes 2 No 1 ☐ Yes 2 € **Division of Vital** 25. Was case referred to medical Be 26. Place of Death heck only one) Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 2 🗌 No n 24 hours after death he Funeral Director: / pleted filled in by the f death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination are sold in the state of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the** I To the only one) 29b. Signature and title of certifier 29c. License number 10

DHMH 17 Rev 7/2009

State Registrar Marke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 28 2009 Jovenber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Min 1 X M 2 □ F 220-61-0761 Yrs 9-15-1952 57 Korea Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show aţ 1 ☐ Yes 2 No Director Catonsville notified MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ъ must be 21244 7135 -C Rolling Bend Road items 23a Korea Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Examiner 1 Never Married 2 Married ö 1 Yes 2 XNo Asian If Yes, Give Year or Dates Specify 2 3 Widowed Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salary Man 12th grade years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Young Sung Il Soon Houng ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22150 19a. Informant's Name/Relationship (Type. Print) 6520 Lee Valley Drive # 302 Springfield, VA Gil Soo Yoo-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial Cremation 3 Removal from State 12-1-2009 Balto, Md Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Extended the Cause (Disease or injury that initiated events resulting in death) Last Due to (or Affrenz burial-trai Due to (or as a consequence of) physician Physician/Medical the as attending nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Year ō in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Inknown 1 🗌 Yes 2 No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one, funeral director. Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ပ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Yes 2 No 2 Accident the 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Box 68760, P.O. of Vital Records,

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

permit.

21215-0036

Maryland

altimore,

The law requires that the death certificate be executed Physiclan: Division

I or Attending F after death. Director 24 hours the the

completely filled in by 2

Medical

29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ate Ketan

600 North Wolfe St, Baltimore, MD, 21287

2009

Movember

City or Town, State)

State Registra

31. Date filed (Month, Day, Year)

4 ☐ Homicide

32. Registrar's Signature

4 and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) ^D23,2009 9:10 P M A. Marie Seltz November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Parkville Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 19, 1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Days Months Hours 1 □ M 2 😾 F Pennsylvania 196-05-5106 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Parkville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8820 Walther Blvd Apt.4307 USA 21234 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2€ No white Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elva Neidermeyer Elmer Eberly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1902 Philadelphia Road-Joppa, Maryland 21085 Diana Lipscomb-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel and Cremation – Belair 1 – 26 – 09 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ordere LME for Evans Funeral Chapel and Cremation Services 8800 Harford Road- Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ('evelow vus cular day disease or condition resulting in death) Theroschero Sequentially list conditions, if any, leading to immediate e of delivery nth Day Year ribute to the cause of death? 4 Unknown 3 Probably Were autopsy findings available prior to completion of cause of death? I □Yes 2 □No er (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

2

Completed

Be

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MD

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rectified at once.

Baltimore, Maryland 21215-0036

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law requires that the death certificate be exect 68760 ed by the a Ö ۵ Vital or Attending Physician: Division after death

Examiner by Physician/Medical Be Completed Certification: To Medical

29b. Signature and title of certifier

31. Date filed (Month,

30. Name and address of person who completed ca

DEC O

Day, Year)

Kaven

causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of): Non-ST elevalum M	~ Mijocandi	dinfue	5dy
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnan 4 ☐ Pregnant at time of death 5 ☐ Other (specify) . 9 ☐ Unknown		23d.	Date of delivery Month Day Yea
Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause g	iven in Part I.		contribute to the cause of deat o 3 Probably 4 Unk
			24a. Was an autopsy performed?	4b. Were autopsy findings ava prior to completion of caus death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	-	26. Place of Death (C	Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2 ER/Outpatient 3 DOA Of	ther: 4. Nursing Home	5 ☐ Residence 6 ☐	Other (Specify)
27. Manne of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury	ury at 28c ork? □Yes 2□No	d. Describe how injury oc	curred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	. Location (Street and No City or Town, State)	umber or Rural Route Number
	sician: To the best of my knowledge, death occurred at the ner: On the basis of examination and/or investigation, in my and manner stated.			

State

Registrar

within 24 hours a

se of death (Item 23a) (Type, Print)

mi

29c. License number

Wather Parkville MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jtar Ks 2:30 A M 26,2009 Novembe /Medical 4c. County of Death Facility Name, (If not institution, give street and number, Town, or Location of Death **Examiner** N In mor Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. ial Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 X M 2□ F 216-68 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ir than "natural", or items 23a or 28a-f show 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 100 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Decedent Ever in U.S. Armed Forces?

No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Madical Examina. 1 Never Married 2 Married 1⊡Yes 2⊠No Baltimore, Maryland 21215-0036 Specify. Blac þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be မ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State rematou 5 ☐ Other (Specify) 4 Donation 21. Signature of Frineral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE CORONARY YEARS **Physician** ARTES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month signed by the at the detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 🗖 Probably 4 🗌 Unknown icate has been sl page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe To the troop....
within 24 hours after death.

To the Funeral Director: After this certificate the funeral director, and a fine funeral director, page. 2X No 1 ☐ Yes 2 ☐ No 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1**½** Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 □ DOA မှ 1 Inpatient 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 34 0016 mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAYANT ANJ 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

DEC 0 1 21

ranko

Division or Vital Records, P.O. Box 68760,

death with the Maryland

Saltimore, Maryland 21215-0036

or items

Examiner law requires that the death certificate be executed the burial-tran attending physician or Attending Physician: 24 hours a the Hospital within 2.

To Be Completed by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of delivery Month Day Yea					
	Part II Other significant conditions	23e. Did tobacco use contribute to the cause of deat					
				24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings ava prior to completion of caus death? 1 Yes 2 No			
	25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)			
	27. Manne of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	3d. Describe how injury occurred			
Medical Certification	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			28f. Location (Street and Number or Rural Route Number City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(and manner stated).						
	29b. Signal a and title of certifier	29d. Date signed (Month, Day, Year)					

ed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Registrar

State

30. Name and a ress of person

DEC

Year)

31. Date filed (Month,

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			For State Registrar	ate of Maryland	•	irtment of l tificate of l		-	giene _{Reg. No.} 200	19 38134
Physician/ Medical Examiner			1. Decedent's Name (First, Middle, Last)				2. Date of Death NOVEMBER 27, 2009 9:19F M			
			Teresa Elaine Sagal 4a. Facility Name (if not institution, give street.)	and number)		4h City Town o	or Location of Deat			
- p- 2		er	Saint Joseph Me	dical Cent			Tow	5 O TI		altimore
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M :	7. Age (In yrs. last 61	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bird Feb • 06	1948 E	. Birthplace (State or Foreign Country) BECKIEY, W.VA.
	nd how at	r	Usual Residence of Decedent 10a, State 10b, County	10c. City. 1	Town or Loc	ation				10d. Inside City Limits
036	farylar 3a-f sl tified	To Be Completed by Funeral Director	Maryland Baltimore		ler					1 🗆 Yes 2 🖾 No
	a or 2		10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
	th with ms 23 must		18414 Falls Road				21023		United	
	e filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 No Yes, Give ear or Dates,	ì	/as Decedent of F Yes, specify Cuba	fispanic Ongin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, V	American Indian, White, etc. White
Baltimore, Maryland 21215-0036	iin 72 hou ie. han "nati e Meuira		15. Decedent's Education (Specify only highest grade continuous Elementary/Seconday (0-12)	npleted) ollege (1-4 or 5+)	(Give k life. DC	NOT use retired)	during most of woi	king	16b. Kind of Busin	
2	ed with Hygier other t		12 17. Father's Name (First, Middle, Last)	01		Home Mak		(Final Addatate	OWN Maiden Surname)	Home
lanc	age 1 and 2 should be file ont of Health and Mental H it: If item 27 is marked of y or other traumatic ever		Kermit Alley				Pauline		Maiden Surname)	
lary	should and M is ma aumat		19a. Informant's Name/Relationship (Type, Pri	int)	19b. Mailin	g Address (Street	•		r, City or Town, State	e, Zip Code)
ა `	and 2.		Mr. Joseph G. Sagal 20a. Method of Disposition				Butler, M		21023	
nore	Page 1 nent of I ant: If its ury or of		1 ☐ Surial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State cem	netery, crem	sition (Name of atory or other place Cath.Ch		Date C.03,	20c. Location - Cit	
alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	Δ .				009	Keyser,	V.VA.
<u>m</u>	an a		Jeffrey 7.	yair, Rz	· Pe	325 York	Road	ves rune Timonium	waryland	ation Ctr.,P.A. 21093
-	Trysician/		23a. Part Ener the disease, or complication shock, or healt failure. List only one cause (Final disease or condition					or respiratory an	est,	Approximate Interval Between Onset and Death
Medical Examiner disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): ATRIAL FIBRILLATION										
1	ed nsit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence consequence).			uence of):				
_	cate be executed physician and the burial-transit									
09/	icate by physics the	ledical	d							
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	in the past 12 months?	yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal d ☐ Pregnant at time of dea ☐ Unknown	eath 3 🗌	Ectopic pregnand Other (specify) _	су		23d. Date o Month	f delivery Day Year
J.	that the	by Ph	Part II. Other significant conditions contribut	ing to death but not resulti	ng in the ur	derlying cause gi	ven in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
ds,	quires en sign ould be	ted k						1 🗆 '	res 2 🗶 No 3 [Probabiy 4 🗆 Unknown
Division of Vital Records,	The law re te has be bage 2 sho	Completed						24a. Was a autop perfo	sy prior deat	e autopsy findings available to completion of cause of h? Yes 2 X No
ā	cian: T	Be C	25. Was case referred to medical examiner?				ace of Death (Che		ZIKNO	165 2 25 110
Ξ	Physic this or	은	1 🗌 Yes 2 🕱 No	1 X Inpatient 2 ☐ ER			4 L Nursing F		ence 6 Other (S	pecify)
o uo	ending Fath. or: After the funera	Certificate:	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	a. Date of injury (Month, Day, Year)	b. Time of injury	28c. Injur work M 1	y at ⟨? Yes 2 □ No	28d. Describe h	ow injury occurred	
DIVIS	oital or Att		4 ☐ Homicide determined 286	e. Place of Injury - At home building, etc. (Specify)				City or Tow	n, State)	Rural Route Number,
	n 24 hc	Medical	29a, Certifier (Check (Check only one) (Check one) (Check only one) (Check one) (Check only one) (Check one) (Ch	the basis of examination ar	nd/or investi	gation, in my opini	on, death occurred	at the time, date a	nd place, and due to	the cause(s) and manner stated.
	To the Complex of the	-	29b. Signature and title of certifier	10		29c. Licens			29d. Date signed (M	onth, Day, Year)
							0263		11-27	-09
	:		30. Name and address of person who complet FRONCIS KHOO W.			,	TANCA	N MADVI	AND 212	17174
	Stat Registra		31. Date filed (Month, Day, Year) DEC 0 1 2009	32. Registrar's Signature		1	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		سطيان ساد 11 كشك المستدين	16 L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month Sholar Mary Jane November 22, 2009 1:10 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery <u>Holy Cross Hospital</u> Silver Spring If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F Days Hours Min. 579-34-7887 81 Dec. 7, Director Maryland 1927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shov adical Exeminer must be notified at 1 ☐ Yes 2X No Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 14639 Bauer Drive United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Travel Agency Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estelle V. Reed Russell L. Copeland 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4806 Randolph Rd. Rockville, Maryland 20852 (daughter) Diane H. Lamas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 25, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State injury or Chesapeake Crematory Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signature of Funeral Service Licensee 933 Gist Ave. Silver Spring, Maryland 20910 M00982 V. 23a. Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Renal Failure /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation with Rapid Ventricular Response Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Fluid Overload attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Ye ar 5 Other (specify) 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Acute Lacunar Infarcts 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Bilateral Carotid Stenosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No certificate Abdominal Mass 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No tX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t funera 28c. Injury at Work? 1 🗓 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a, Certifier 1🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

Mary Wright, M.D. Holy Cross Hospital 1500 Forest Glen Rd. Silver Spring, MD 20910

D005618

29d. Date signed (Month, Day, Year)

November 22, 2009

To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b

Medical

29a. Certifier

(Check only one

29b. Signature and title of certifie

AT2438946B35 November 28,2009 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Judith Kopinski 201 E. University PKWY, Baltimore, 40 21218 Union Memorial Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Deborah D. Smith OVEMBER Year 2121 12:05FM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death $\mathbb{H} \oplus \mathbb{I}$ 4b. City, Town, or Location of Death Saint Joseph Medical Center owson timore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 XX 219-70-2123 Director 54 1955 MD Nov Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Parkville 1 ☐ Yes 2**XX**No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8800 Lakewood Road 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces "natural", or Completed by 1 Never Married 2 Married Yes 2XXNo Specify. White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea gnose. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest P. Smith, Jr. ပ Gaynell Carlisle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Smith (Son) <u>8624 Oakleigh Road Balto.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Crestlawn Memorial XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/30/09 Marriottsville, MD of Fundal Salvice 22. Name and Address of Facility urgee-Henss-Seitz Funeral Home Inc. Falls Road MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician MALIGNANT ARRHYTHMIA disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events the burial-transi physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month ate has been signed by the atte page 2 should be detached for Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISEASE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an death? certificate 1 ☐ Yes 2 X No 1 L Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No 2 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) To the Hospital Medical 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗔 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 109 D31674

Registrar

State

31. Date filed

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OSLER DRIVE

TOWSON, MARYLAND 21204

s of person who completed cause of death (Item 23a) (Type, Print)

M. D.

32. Registrar's Smature

BERNSTEIN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#29d, perDVR, G898, 12/1/09, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 2. Date of Death
Month Day
11-25-2009 1. Decedent's Name (First, Middle, Last) Marian Elizabeth Stuhmer 930 A 4c. County of Oeath 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 455 Deer Hill Circle Abingdon Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 03^{Mo}1^{t2} Day9^Y9²6 Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) 93 1 ☐ M 2X F Yrs 213-72-9415 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21014 Crocker Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Boehm Albert Ritterpusch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28s-f show eny injury or other traumatic event, Ite Medical Evantual the notified at ODEs. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

MD

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Director

Funeral

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Completed

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Funeral

Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit ettending pl ed by the e ate has been signed by page 2 should be detach within 24 hours after death. To the Funeral Director: After this certific cimpletely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

	Henry A. Stuhmer	(Son)	1410 Moonsha	adow Rd Bel	Air, MD 2	21015		
	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	of Disposition (Name of tery, crematory or other p	1		ocation - City or			
	21. Signature of Funeral Service Licen	22. Name and Add	22. Name and Address of Facility Schimunek Funeral Home of Bela: Inc 610 W. MacPhail Rd Bel Air, MD 21014					
	shock, or heart failure. List only	plications that caused the death. Done cause on each line.		t enter the mode of dying, such as cardiac or respiratory arre-			Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)	ease or condition						
aminer	Sequentially list conditions, if any, leading to immediate cause. Enser underlying Cause (Disease or injury that initiated events							
edical Ex	resulting in death) Last	Due to (or as a consequence d.	e of):					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	12 months? 4 □ Pregnant at time of death 5 □ Other (specify)						
d by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 I							
Complete	autopsy prior to performed? death						utopsy findings available completion of cause of 25 No	
Be	25. Was case referred to medical examiner?	25. Was case referred to medical 26. Place of Death (Check only one)						
0	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (5					6 Other (Spe	kity) Kustaence	
atlon:	27. Manner of Death Natural 5 Pending Accident investigation	(Month, Day Year)	o. Time of 28c. In Injury V	njury at 2: Vork? ☐ Yes 2 ☐ No	8d. Describe how injury occurred			
Certific	3 Suicide 6 Could not be 4 Homicide determined	farm, street, factory, office	m, street, factory, office 28f. Loc Cit		ocation (Street and Number or Rural Route Number, ity or Town, State)			
Medical Certification:	23d. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
Ž	29b. Signature and title of certifier	eb. Signature and title of certifier			Nov	29d. Date signed (Month, Day, Year) November 27,2009 Rouch 2, 2007		
	30. Name and address of person who	completed cause of death (Item 23a		2299				

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day **Physician** 266 Pauline Grace Spiker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner +1 ROSE dale If Under 1 Year | If Under 24 Hrs more 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Nov 5, 1922 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** West Virginia Days Min 1 □ M 2 🛣 F 235-30-3503 87 Nov Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Predical Eventral inset or maithed at 1 ☐ Yes 2 X No Director Middle River MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 USA 3518 Wheelhouse Road Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ≥ ZNNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ith and Mental F. John Fielden Mitchell Rose Victoria Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau Once. 6 Plateau Place Unit T Greenbelt, MD 20770 Rochelle Spiker/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 11/29/09 | Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rforatio OWE /Medical Due to (or as a consequence of): Examiner reumop Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): burial-trar attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 3 Ectopic pregnancy Month Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

Pages 1 and 2

State Registrar

Medical

29a. Certifier

29b. Signature and title of

VASILIADES, M.D

29c. License number

DO064751

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

09

11/26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, MD 2/237 31. Date filed (Month, Day Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 200 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oak Crest Parkville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In vrs. last birthday) **Funeral** 212-03-4618 1 ☐ M 2 🕱 F Min. Feb 1, 1917 **Director** 92 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 ☐ Yes 2 🎖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd Funeral #1106 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: White Specify: Completed 3 ₩ Widowed 4 Divorced Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en David Frederick Cramer Wilhelmina Heinekamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2245 Merion Pond Woodstock, Maryland 21163 Evelyn Cramer / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place New Cathedral Cemetery 12/2/2009 Baltimore, Maryland 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death page 2 should be detached Unknown 9 Unknown $\sqrt{\xi} | \sqrt{\lambda}$ $\int_{C} h \, \omega / Z$ Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ပ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A М 1 Tes 2 | No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sia e and title of certifie 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ 6:05 Charles Norbert Sudina Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** 1 Blenmont Court Phoenix Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** X M 2 □ F 61 Months Augnt 25ay, Yel 1948 Countr Mary land 215-52-2193 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2XX No Phoenix Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21131 1 Blenmont Court Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Exec Search Firm College (1-4 or 5+) Elementary/Seconday (0-12) President & CEO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Bobenko should be Charles John Sudina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Sudina / Wife Phoenix, Maryland 21131 Page 1 and 2 Blenmont Court 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State 12/3/2009 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ardiac disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner months Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy sate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year 5 Dther (specify) Pregnant at time of death Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate I 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗗 No 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work' 2 🗌 No after death Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

\5 State 29b. Signature an

GAUTAM VENICAT

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

UNIVERSITY OF MARYLAND

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11/30/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #1, per MD 8898 12/1/09 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26 2009 NOVEMBER **Physician** 9:20 P M Theodore Sobkov /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner CARROLL SYKESVILLE COPPER RIDGE NURSING HOME 8. Date of Birth (Month, Day, Year) 03/12/1937 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**√** M 2□ F Months Days Hours 216-34-0947 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show d other than "natural", or items 23a or 28a-f shovevent, Inv. Medical Examiner must be notified at MD N/A BALTIMORE 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with Hygiene. USA 21218 3704 N. CHARLES STREET, #404 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 3 Widowed 4 Divorced Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: WHITE 2 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PERIODONTIST DENTISTRY permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GOLDBERG SAMUEL SOBKOV MINNIE ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3704 N. CHARLES STREET, #404, BALTIMORE, MD 21218 JOAN SOBKOV/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEM.PARK 11/30/2009 | REISTERSTOWN, MD 4 □ Ponation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. e of Funeral Service L 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or compocations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a d be detached f 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown icate has been si 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy Hospital or Attending Physician; The certificate 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hin 24 hours after death. the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State

Registrar

Medical

29a, Certifier

(Check only

29b. Signature and title of certifier

completely

within 7

and manner stated.

32. Registrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10c of Maryland, Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 0,5 47 AM 0 1 CAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pikesvill BEI home Love If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 01/12/1915 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min 1 ☐ M 2 👿 F 94 Yrs. MD 219-01-3621 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene.

ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examinations to netter traumatic event, the Modical Examinations to netter traumatic event, Pikesville 1 ∐Yes 2 🙀 No Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 6 BRANCHWOOD COURT Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 MXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KATE KARLOFF BENJAMIN HENDIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 54 WOODWARD LANE, LUTHERVILE, MD. BENJAMIN S. SCHAPIRO / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. BETH TFILOH CEMETERY 11/29/2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 1005918 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Lours

31. Date filed (Month, Day,

Da

Year)

Hopky

Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 26, 2009 **Physician** 6:41 A M SIGELMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE 8. Date of Birth (Month, Bay, 1921 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1 ☐ M 2 ★ Days Min Country) MD 220-01-2526 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exemplant must be notified at 1 ☐ Yes 2X No Director MD BALTIMORE PIKESVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 POMONA WEST, APARTMENT #1 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 □Yes 2 No þ Specify Specify: 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withii Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, If a line. HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS FISH SHIRLEY FRIED ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3214 HEARTHSTONE ROAD, ELLICOTT CITY, MD 21042 SUSAN HORN/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 11-29-2009 BALTIMORE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens SOL LEVINSON & BROS., INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate interest additional contents. Immediate Cause (Final Immediate (Final Immedi Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an page 2 s autopsy performe certificate 1 ☐ Yes 2[25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗐 🕅 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

Day, Year)

DEC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

DHMH 17 Rev 1/2001

29c. License number

808

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** STERN RALPH 27, 05:13A M NOVEMBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3213 NORTHMONT ROAD BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/07/1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 **X** M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 188-18-3747 86 Director GÉRMANY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other tranmatic event, it is Medical frammer must be recitled at any or other tranmatic event, it is Medical frammer must be recitled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County BALTIMORE 1 X Yes 2 □ No N/A Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3213 NORTHMONT ROAD 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE ģ ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN **EQUINE SUPPLIES** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JULIUS STERN AUGUSTA UNKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JEFFREY STERN / SON 133 SUNNYDALE WAY REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition CHEVRA AHAVAS CHESED 11/29/2009 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or RANDALLSTOWN, MD ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. e of Funeral Service 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final FAILURE **Physician** ONGESTIVE HEART disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EVERE STENDSIS DORTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed ARTER CORONAR attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 15 CHEMIC Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à DYSLIPEDEMIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed DIABETES TYPE . Were autopsy findings available prior to completion of cause of death? cate has b page 2 sl 24a. Was an autopsy performed CHRONG KIONEY 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation neral Director: P 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

24 hours within 24 hou **To the Fune** completely fi

> State Registrar

29b. Signature and title of certifier

MIGUEL

SADOVHIK 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILFORD Mill Rd SUITE 105. 201 park

MD

29c. License number

28048

29d. Date signed (Month, Day, Year)

PIKESVILLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 24. 2009 Sullivan /Medical November 4:30 P Robinson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford <u>2308 Watervale Road</u> Fallston 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 😾 F Months Hours Director 213-38-5043 98 July 26, 1911 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits or items 23a or 28a-f show other traumatic event, the Medical Examiner rount be notified at Be Completed by Funeral Director 1 ☐ Yes 2 ☐ Xo Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2308 Watervale Road 21047 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evant Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clayton Riley Robinson Sarah Montique Blair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. John Sullivan / Son P.O. Box 193, Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John Catholic Cem 12-2-09 Long Green, Maryland 21. Signature of Funeral Service Licenses Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause N each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician texnosc YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Das to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 1⊟Yes € 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier € detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

MO55 32. Redistrar's Signature barker

completed cause of death (Item 23a) (Type, Print)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greanough

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32/Registrar's Signature

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barke

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29d. Date signed (Month, Day, Year)

Rayview circle

November 30,2009

09-09204 Steven Taylor

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Physician (Medical Xaminor) 239. Part Lefter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each rine. However Oriset and Enterve List only one cause on each rine. 249. Part Lefter the disease or complications or condition resulting in death) 250. Part Lefter the disease or complications or condition resulting in death) 251. Part Lefter the disease or complications or condition resulting in death) 252. Part Lefter the disease or complications or condition resulting in death) 253. Date of or as a consequence of): 254. Date of or as a consequence of): 255. Date of or as a consequence of): 256. Date of or as a consequence of): 257. Date of delivery 258. Date of Death (Check orly) 258. Was case referred to medical 258. Was case referred to medical 259. Was case referred to medical 250. Was case referred to medical	er death wii or items	Funera	1 X Never Married 2 Married	Armed Forces? 1 Yes 2 X No	If Yes, specify O	uban, Mexican, Puerto		White, etc.	African
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	neral		5. Social Security Number	6. Sex 1 ☐ M 2 🗶 F	7. Age (In <i>yr</i> s.		If Under 1 Year Months Days	If Under 24			9. Bir	thplace (State or Foreign untry)
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ryland	-f sho	ctor	10a. State 10b. County	n/a		ity,Town or Lo Baltim						10d. Inside City Limits 1 Yes 2 □ No
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re, r	other t		Carolane Wil 20a. Method of Disposition	<u>liams-d</u>		Place of Dispo	sition (Name of		Street Date		tion - City or	D 21210
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Baltimore, permit. Page 1 and Department of Hea	any inj		21. Signature of Funeral Service L	icensee			2. Name and Add:		March h Avenue			MD 21202
	ician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on ea			er the mode of dy	ing, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between Onset and Death 30 mins
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DIVISION tal or Attendin rs after death.	d in by	ပ	4 ☐ Homicide determ	inad 28e. Place	e of Injury - At I ing, etc. (Speci		eet, factory, office			(Street and Nown, State)	lumber or Ru	ıral Route Number,
Hospita Hospita 4 hours	runera ted fille	Medical	(Check 2 Medical E	xaminer: On the ba	sis of examinati	on and/or inves	stigation, in my opi	nion, death occu		and place, ar	nd due to the	cause(s) and manner stated.
To the Within	o the	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner:	To the best of r	ny knowledge,		the time, date ar se number	nd place, and due to		nd manner as signed (Mont	
) Park	Key	; MD			0533		Novem	ber	29 2009
,			30. Name and address of person Wene			m 23a) (Type,	Print) Pau	1 Km	Pakuz	Ball		21218
R	Stat egistra		31. Date filed (Month, Day, Year)		egistrar's Sign	nature /	harles		13 400 604	- Contract	*****	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#29a&30perDVR, G898, 12/1/09, WS State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BAN TOWNSAND 440 AM November 22 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care Lochearn Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Vear Months Days Hours Director 81 09/16/1928 240-32-3741 Usual Residence of Decedent Carolina 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ortant: If item 27 is marked .ther than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2540 Madison Avenue 21217 U.S.A Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Completed by 3 ☐ Widowed 4 🔀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Quality Control Elementary/Secondary (0-12) College (1-4or 5+) Insurance years Pitney Bowes permit. Pages 1 and 2 should be file Department of Health and Menta. Hy Important: If Item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Maggie McFadden ٥ Unknown 19a. Informant's Name/Relationship (Type. Print) (Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2540 Madison Ave., Balto., MD 21217 Stephannie Easterling Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Joseph Brown F/H
And Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/28/09 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. FuneralHome 2140 N. Fulton Ave., Baltimore, MD OR 10 21217 a/Pert1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) KIDNSY FAILURE **Physician** 441001743 /Medical Due to (or as a consequence of): Examiner SCHELIC CANDIONGOINN > / L MONTALS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner OLONALY NRTSKY >124MMS and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ∏Yes 2 ∏No 2 Accident investigation within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) XNurse Practitioner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) CLW K088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen C. Diamond Future Care Lochearn 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 000

		•	For State Registrar			iai y rai i a	Cer	rtificate of I	Death		Reg. No.	009	38	121
	Physicia		1. Decedent's Name (First, Mi	ddle, Last)						2. Date of Dea	ath Day	Year	3. Time of	Death
	/Medic	al	Claude G.							Novemb	er 11,	2009	4:00	PM M
	Examin	er	4a. Facility Name (If not institue) 600 D Cart)			Location of Death		4c. Coi	unty of Death Cecil		
A ^E	Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h _{Varia}	9. Birthp	lace (State o	or Foreign
	Director		213-36-7575	1 🖾	M 2□F	70	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da Oct 9,	1939	Mary		
7	gug w		Usual Residence of Decedent 10a. State 10b. Cou	ntv		10c City	Town or Lo	cation				1	0d. Inside Ci	ity Limits
	Maryla f sho	ō		imore			yvi11						1 □Yes	
	r 28a	Director	10e. Street and Number	- Ino I o		1		10f. Zip Code			10g. Citizen	of What Coun	ntry?	
	th with	alD	600D Carter C	ourt				21903			USA			
	rdea	Funeral	11. Marital Status		2. Was Deceden Armed Forces	2	13. \	Was Decedent of H	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14.	Race - Americ Black, White, e		
36	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the Hygiene. the Warland the Warland I was not the Maryland and the Maryland I was not not the Comment, it is the Maryland I was not	by F	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☑ Divor		1 X Yes 2 ☐ If Yes, Give Year or Dates			1 □Yes 21☑No	Specify:		Sp	ecify:whit	e	
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and	d be fi) Be	John Carroll		S				Sara Reb			name)		
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altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is the after Examination in the result of once.		4⊠Donation 5 Dothe	(Specify)	1/4		20	Name and Addre	es of Facility		_			
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	uted d insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	Pol	/ / Source	rolas	Alreio >	matic	A 17	25)	1541	066
oʻ	e exectan and and rial-tra	Еха	that initiated events resulting in death) Last	c.	Due to (or a	s'a conseque	ence of)	· VICCO	IIIA D					1
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ord	w require been signal									1 🗆	Yes 2□!	No 3 Prot	bably 4	Unknown
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Division of Vital Records,	or Atl after d Direct in by	Certification: To	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide del	uld not be ermined	28e. Place of li building,	njury - At hom etc. <i>(Specify)</i>	ne, farm, str	reet, factory, office		28f. Location (City or To	Street and N wn, State)	lumber or Run	al Route Nur	nber,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit							th occurred at the ti						
	the Ho nin 24 I the Fu thetel	Medical	(Check only 2 Medione)	cal Examin	er: On the basis and manner:		on and/or ir	nvestigation, in my	opinion, death occu	urred at the time	date and pl	ace, and due t	o the cause(s)
	To To	2	29b. Signature and title of cer	differ /	01)1K	(100)	P	29c. Licens	se number		29d. Date s	signed (Month,	Day, Year)	
			30 Name and address of ac-	1137	mpleted square	death /ltow	23a) /Time	Print)	(2/	4.1	2	1.010		
			30. Name and address of per William	MIC	CAN	Paul (Hem)	OO L	och Ri	AUEN BI	Vd t	altin	now, 1	(D21)	118
	Sta		31. Date filed (Month, Day, Y	ar)	32. Regis	strar's Signatu	ire A	20		· · · · · · · · · · · · · · · · · · ·	-			
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State of Maryland / Department of Health and Mental Hygiene

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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 [arital Status Never Married		12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give		l l		edent of Hi ecify Cubar 2 No			ecify Yes or No Rican, etc.)	-		White, e	tc.
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Balti	permit. Page Department Important: II any injury or once.		21. Sig	gnature of Fune	ral Service Licens	Moi	443	22					neral A				and 21286
			23a. F	Part 1. Enter the shock, or heart f	disease, or compailure. List only or	lications that caused e cause on each line	the death	. Do not ente	r the mo	de of dying	g, such as	cardiac o	or respiratory a	arrest,			Approximate interval Between
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yo.	ath certificate be executed attending physician and for use as the burial-transit		that in	nitiated events ting in death) La		c. Due to (or as a	conseque	ence of):								\top	
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Division of Vital Records,	• Hospital or Attending Physician: The law requires that the death certificate be executed 24 burs after death. • Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit			☐ Suicide ☐ Homicide	6 L Could not be determined	28e. Place of Inju building, etc			et, facto	ry, office			28f. Location City or To			or Rural	Route Number,
7	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director Attle this certificate has completed filled in by the funeral director, page 2	Medical	((Check 2 🛚	Medical Exami	ician; To the best of ener: On the basis of ener to the	amination	and/or invest	igation, i	ny opinio	n, death o	occurred a	the time, date	and plac	e, and due to	the cau	se(s) and manner stated.
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	Y		31. Da	ate filed (Month,	Day, Year)	32. Registra	1/	50	1	708	117	tec	bVc	1 5	- Hen	BV	Knid Los
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TEAGUE, JAMES, D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Mary Tridone 26. 2009 11:48 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗔 F 11, Director 213-03-3750 Nov. 1917 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas pepartment of Health and Mental Hygiens. In pepare the state of 1 □Yes 2 □ No Director MD Lutherville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8517 Valleyfield Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No þ Specify: Baltimore, Maryland 21215-0036 Specify: 3

Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Santino Donati 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 8517 Valleyfield Road; Lutherville, MD 21093 Mary D. Tridone 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Aremation 3 ☐ Removal from State Most Holy Redeemer 12/2/09 Baltimore, MD 1050 York Road 21. Signature of Fur 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition days neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncorlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of) Box 68760. attending physiclan for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Tithknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 🗖 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed certificate has been hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐Yes 2 12 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 ₹No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier F Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

State Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

R Motagi,

D52197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

11-26-2009

REKHA MOTAGE, M.D. GBMC 6701 N. CHARLES ST. BALTEMORE, MD 21294
31. Date filed (Month, Day, Year)

DEC 0 1 2009 32. Bigistra's Signature).

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38154 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOWEMBER 26 2009 Physician/ 2:15 RICHARD TOBIN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Country) NY **Funeral** 1 🔀 M 2 🗆 F Months Days Hours 11/30/1946 62 Yrs. Director 077-38-5741 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar many once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Tes 2 X No HOWARD COLUMBIA MD 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21046 7310 KINDLER ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 2 X No ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) PROJECT MANAGER CONSTRUCTION Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ည PANKEN TOBIN SYLVIA FRANK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7310 KINDLER ROAD, COLUMBIA, MD. HARRIET TOBIN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State COLUMBIA MEMORIAL PK 11/29/2009 |COLUMBIA, MD 4 Donation 5 Other (Specify) ineral Service Line 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Leath Immediate Cause (Final arrinom Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death ☐ Pregnam.
☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 2 X No 4 Nursing Home 5 Residence 6 2 Other (Specify) 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28b. Time of Manner of De th 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signat D681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bust

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registra

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CAROL ANN TANE CAROL ANN TANE Facility Name (If not institution, give UPPER CHESAPEA Social Security Number 17-38-8622 Juli Residence of Decedent 1. State 10b. County Arryland Harford Street and Number 641 Gairloch Pla Marital Status 1 Never Married 15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12) Father's Name (First, Middle, Last) Charles Edward Factorial A. Informant's Name/Relationship (10) Autid Tanenbaum / 10. Method of Disposition 1 Burial 2 Cremation 3 All Donation 5 Other (Specify Signature of Funeral Service Licenses) A. Part 1. Ent. I the disease, or composition of the property of the pr	ace 12. Was Decedent E Armed Forces? 1 Yes, Give Year or Dates: 14. Andrews Type. Print) Husband Removal from State 13. Removal from State 14. Andrews 15. Andrews 16. Andrews 17. Age 17. Age 18. Andrews 19. Andr	(In yrs. lass 68 10c. City, 1 Bel Ever in U.S. Io 20b. Place Cem	In thirthday) Yrs. Fown or Local Air 13. Willing 16a. Deceder (Give ki life. DO PSychi 19b. Mailing 641 G Decedery, crema Local Local 13	as Decedent of Fives, specify Cub Yes as No Int's Usual Occuping of work done O NOT use retire atric Na Address (Street airloch tion (Name of atroy or other pla ervice (Name and Addre Comas Fi 17 Cokes	tispanic Originan, Mexican, Pispecify: batton during most of d) 18. Mother's Mary and Number of Pl. Bece) pass of Facility Ineral 1	R. Date of B. (Month, I. NOV. 2) R. (Specify Yes or Nuerto Rican, etc.) Working Assistant Name (First, Middle Dorothy For Rural Route Num. Par Rural Route Num. 1-25-09 Home, P. J.	10g. Citi USA 10b. Ki USA 10c. Men: 16b. Ki USA 10c. Lo 170W	941 Mar izen of What Cou 14. Race - Ameri Black, White, Specify: White ind of Business/Ir tal Heal Surname) enship or Town, State, Zi 015 coation - City or To	nplace (State or Fore intry) ryland 10d. Inside City Lim 1 □ Yes 2 □ N intry? ican Indian, etc. nite industry Lth for Code)
UPPER CHESAPEA Social Security Number 6. Second Security Number 6. Second Security Number 6. Second	Andrews Type. Print) Hemoval from State WEDICAL 7. Age 8. Armode Forces? 9. Age 1. Age	(In yrs. lass 68 10c. City, 1 Bel Ever in U.S. Io 20b. Place Cem	In thirthday) Yrs. Fown or Local Air 13. Willing 16a. Deceder (Give ki life. DO PSychi 19b. Mailing 641 G Decedery, crema Local Local 13	BEIL A If Under 1 Year Months Days ation 10f. Zip Code 21015 as Decedent of It fes, specify Cub Yes & No ont's Usual Occupind of work done O NOT use retire atric No Address (Street airloch tion (Name of ntory or other pla ervice (Name and Addre Comas Fu 17 Cokes	tispanic Originan, Mexican, Pispecify: batton during most of d) 18. Mother's Mary and Number of Pl. Bece) pass of Facility Ineral 1	R. Date of B. (Month, I. NOV. 2) R. (Specify Yes or Nuerto Rican, etc.) Working Assistant Name (First, Middle Dorothy For Rural Route Num. Par Rural Route Num. 1-25-09 Home, P. J.	10g. Citi USA 10b. Ki USA 10c. Men: 16b. Ki USA 10c. Lo 170W	County of Death IARFORD 9. Birth Cou 941 Mar izen of What Cou 14. Race - Ameri Black, White, Specify: Wh ind of Business/Ir tal Heal Surname) enship or Town, State, Zi 015 coation - City or To	Inplace (State or Fore Intry) Tyland 10d. Inside City Lim 1 □ Yes 2 □ N Intry? Ican Indian, etc. Ite Industry Lth Town, State
Social Security Number 17–38–8622 Jail Residence of Decedent State 10b. County Aryland Harford Street and Number 641 Gairloch Pla Marital Status 1 Never Married 15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) Father's Name (First, Middle, Last) Charles Edward Fa. Informant's Name/Relationship (10) Avid Tanenbaum / 10. Method of Disposition 1 Burial 2 Cremation 3 Amendation of Disposition of Disposit	ace 12. Was Decedent E Armed Forces? 1 Yes 2g N If Yes, Give Year or Dates: Jucation Adde completed) College (1-4or 5-4) Andrews Type. Print) Husband Removal from State (y)	(In yrs. lass 68 10c. City, 1 Bel Ever in U.S. Io 20b. Place Cem	13. William 15. Mailing 641 Government 15. Mailing 641 Government 15. Mailing	ation 10f. Zip Code 21015 as Decedent of Pres, specify Cub Yes & No Int's Usual Occuping of work done O NOT use retire atric Na Address (Street airloch tion (Name of ntory or other pla ervice (Name and Addre Comas Ft 17 Cokes	dispanic Originan, Mexican, Pispecify: Dation during most of d) 18. Mother's Mary and Number o Pl. Bece) Corp. 1 Sor of Facility Ineral	(Month, I NOV.) ? (Specify Yes or Nuerto Rican, etc.) working Assistant Name (First, Middle Dorothy For Rural Route Num. el Air, Note 1-25-09 Home, P. J.	irth Day, Year) 22, 1 10g. Citi USA 16b. Ki - Menn 81 ank bber, City of D 21 20c. Lo	941 Mar 941 Mar izen of What Cou 14. Race - Ameria Black, White, Specify: White of Business/Ir tal Heal Surname) enship or Town, State, Zi O15 coation - City or To	intry) Cyland 10d. Inside City Lim 1 Yes 2 intry? ican Indian, etc. nite industry Lth ip Code) Town, State
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ease or condition sulting in death)	a. Due to o as a	14	1 7 7 7	oto of	Sie F	Blackba	- Co	1050-	Interval Between Onset and Death
		a consequer	nce of):	2/43/4	72	J1-4057	- 0		morm
Sequentially list conditions. If any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									10 days
quentially list conditions, ny, leading to immediate use. Enter Underlying	∪ue to (or as a	consequer	nce of):	f.,		, ,	//		
use. Enter Underlying use (Disease or injury t initiated events ulting in death) Last	c	Me	tabe	ike	Ence	phalopo	14		to deep
uning in death) Last	Due to (or as a	a consequer	nce of):		,				
	d								
FEMALE:	23c. If ves. outcome of	of pregnanc	v					22d Date of dolin	VOD.
in the past 12 months?	1 Live birth 2	2 🗌 Fetal de	eath 3 🗆 I		у			Month	Day Year
1 □ Yes 2 BNo 9 □ Unknown	9 Unknown			outer (aposity) _					
t II. Other significant conditions co	ontributing to death but	ıt not resultir	ng in the und	erlying cause giv	ven in Part I.	23e. Dio	I tobacco ι	use contribute to	the cause of death?
						1□	Yes 2	No 3□ Pro	bably 4 🗆 Unkno
								24b. Were aut	topsy findings availa
						per	formed?	death?	ompletion of cause
Was case referred to medical		-			26. Place of			1 Lives	2 LIN0
examiner? 1 Yes 2 No	Hospital:	nt 2 EF	R/Outpatient	3 □ DOA Oth	105'			6 □Other (Spec	cifv)
Manner of Death				28c. Inju	ry at				
2 ☐ Accident investigation	1	, , , , , ,	inguity						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Zoe. Place of Injul	ry - At home . (Specify)	e, farm, stree	et, factory, office		28f. Location City or To	(Street an own, State	nd Number or Rui	ral Route Number,
	niner: On the basis of	examination							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and man manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed								te signed (Month	, Day, Year)
*	1	MD		100	0566	07	24	Nove	mber 20
Name and address of pers who o	₹ completed cause of de		3a) (Type, Pr	rint)					1
					0 1-		0 1	0 6	
We ex 11 MM 11 22 33 44 No. 55 55 55 55 55 55 55 55 55 55 55 55 55	Was decedent pregnant in the past 12 months? 1	Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1. Other significant conditions contributing to death but was case referred to medical xaminer? Yes 2 No Hospital: Inpatie	d. 23c. If yes, outcome of pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 1 Unknown 1 Unknown 2	d	d	d	Ass case referred to medical Alaminer? Ass case referred to medical Alaminer? Ass case referred to medical Alaminer (Check only Alaminer) Alaminer (Check only Alam	Addition to be past 12 months? 23c. If yes, outcome of pregnancy 1	d

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Justin	Vickers

stin Vickers		St 1- For State	ate of Marylan		rtment of		and N	Mental I			200	1 9	38	156
Physicia		Registrar 1. Decedent's Name (First, Middl	e,Last)			D'Outi,			2. Date of De				e of Death	<u>-</u>
edical Exami	ner	Justin David	Vickers						November November	er 22, 2009	Year 9	112	25 hrs	
		4a. Facility Name (if not institution		per)	4	b. City, Town			ath		unty of Dear	th		
		Harford Memorial Hos				Havre de				Harf			(0)-1	
Funeral Director		5. Social Security Number		. Age (In yrs. la	ast birthday)	If Under 1 Months	_	If Under 24H Hours N	lin.	Birth (MM/DD/)	Fore	ian		
Director		218-21-8407	1 XM 2 F	2	21 Yrs				Aug.	17, 19	88 ^c	ountry Ma	arylar	nd_
á	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	ion						10d. In	side City Li	mits
d how a		Maryland Har	ford	For	cost Ui	11						1	Yes 2 X	No
Maryland 28a-f show any 1 at once.	Director	10e. Street and Number	LOLG	1 101	cest Hi	10f. Zip Cod	de			10g. Citizen	of What Co	untry?		_
the M	ä	2035 Garden D	rive			210	50			USA				_
72 hours after death with the Maryland n "natural", or items 23a or 28a-f shor al Examiner must be notified at once.	uneral	11. Marital Status	12. Was Deced			s Decedent o	f Hispar		Specify Yes or N	lo- 14.	Race - Ame	rican Ind	ian, Black,	
death or iter	, i	- I home	arried Armed Ford	2 X No		•			rto Rican, etc.)		White, etc.			
s after	þ		orced If Yes, Give Year or Dates:			Yes 2 X					cify: Wh			
hours 'natn		 Decedent's Education (Spe Elementary/Secondary (0-12) 			16a. Deceden during m	it's Usual Occ ost of working				16b. Kind	of Business	s/Industry		
36 hin 72 e. than	ple	Liemental y/Secondal y (0-12)	4	, OI 34)	C+nd.	on+				Co	llege			İ
21215-0036 utld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	17. Father's Name (First, Middle			Stud	ent	18.	Mother's Na	me (First, Middle				-	\dashv
215 be file ntal H rked o	Be (David Walter	Vickers				l M	4elodi	Daun O	Lson				
D 21215-0036 should be filed within and Mental Hygiene. 7 is marked other than artic event, the Medic	P	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (S			or Rural Route N		r Town, Sta	te, Zip Co	ode)	Ī.
MD nd 2 sho alth and m 27 is aumati	Ч	Melodi Daun V	<u>ickers / M</u>						Forest Date	Hill,	Mary	<u>land</u>	2105	50
Sre, sslar of Hea If ite		20a. Method of Disposition 1 XBurial 2 Cremation	n 3 Removal from		Place of Dispos crematory or ot		r cemet	tery,	Date	20c. Loca	ition - City (or rown,	state	
caltimore, rmit. Pages I ar spartment of He iportant: If ite		4 Donation 5 Other S		Hic					1/28/09					ĬE
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service	Licensee			Name and Add			McComas				.A.	
Physician	3	23a. Part I Enter the disease, or	complications that cau	sed the death	. Do not enter t	he mode of d	Dadw ving, sur	vay, B ch as cardia	el Air,	Mary L	and 2.		roximate Inte	erval
/Medical	1 17	failure. List only one cause	on each line.		alcoho							Bet	ween Onset Death	and
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c)I IIIC	MIC	acton				_		
		Sequentially list conditions,	b									-		
	ine	if any, leading to immediate	Due to (or as a c	onsequence o	of):									
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executed an and al - transit		- *7	d											
be be	edical	Xunpended	AMENDED 23	3a,27,2	28a-f,pe	ermE, s	3898	12/4	/09 TT					
Box 68760 : death certificate I he attending phys	Physician/M	IF FEMALE: 23b. Was decedent pregnant in t	Z3C. If yes, ou	atcome or preg	nancy	etal death	_	Ectopic pre			ate of deliventh	ery Day	Year	,
th cert	icia	past 12 months?		nt at time of de	noth	ther (Specify)								1
Bo he deat the at hed for	hys		known g Unknow	SINDER - CO			-	1. Deat	One Div	tobacco use	o o o o o i o o o o o o o o o o o o o o	to the co.	on of don't	-2
lecords, P.O. Box 6876. The law requires that the death certificate at thas been signed by the attending phyage 2 should be detached for use as the t	by F	Part II. Other significant condi	nons contributing to d	death but not r	resulting in the	underlying ca	use give	en in Pari i.		Yes 2 N				- 1
dS, I													findings ava	
Records, The law requir ficate has been s	Completed	 							au	topsy rformed?		o comple	tion of cause	
DZ [2 4]								15 11 101	1 ✔ Ye	s 2No	1 🗸	Yes	2 N	No
	Be	25. Was case referred to medica examiner?	11 2 1	nationt 2 M	ER/Outpatien		lo:	hor:	rsing Home 5	Residence	6 Ot	her:		-
n of Vi ding Physi After this funeral dir	<u>1</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	f Injury	28b. Time of			at Work?	28d Describ	ne how injury	occurred			
_ = . ^ ≥	tion	1 Natural 5 Pen	(Month, I	Day, Year) /22/09	Fd 10:	(O am 1	Yes	s 2 X No	subjec alcoho	t inge	sted	drug	s and	
Division tal or Attendi rs after death. al Director:	fica				nome, farm, stre		fice buil	lding, etc.	28f. Location	n (Street and	Number or	Rural Ro	ute Number	r, City
Dital of ours affect in Diffilled in	Certification: T		ermined (Specify)	house	е				501° S.	, State) Union	Ave	Havr	e De (Grade
Division To the Hospital or Attent within 24 hours after death To the Foneral Director:			hysician: To the best										()	
within to the complex per per per per per per per per per per	Medical		aminer: On the basis of and manner sta		and/or investiga				ed at the time, da					4
	Σ	29b. Signature and title of certifi	er				icense r				e signed (ıy, Year)	
		Yashel TV	uttull, 1	M)			D.C.M.	.⊑.		Nover	nber 23,	2009		
		30. Name and address of person Pamela E. Southall, I				11 Penn S	treet	Baltimore	e, MD 21201					
	ate	31. Date filed (Month, Day, Year)		rstrar's Signal	huro			Januarion	-, ITIO 2 12VI					
Regis					A A	arkel								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2909 **Physician** Mususen HARLES WITTMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homei Mr Baltimore City CENTER BAUTINWRE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, July 13, 7. Age (In yrs. last birthday) Social Security Number **Funeral** Year) 1929 Months Hours Days 80 213-26-0229 July Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Evar, item rust be notified at 1 □Yes 2 ₽ No **Funeral Director** Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 U.S.A. 573 Shipley Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Utility Company Senior Project Designer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Charles Wittman Unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health i Mrs. Jacqueline Winter/daughter 448 Kingwood Road; Linthicum, Maryland 21090 Department of Health Important: If Item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Dec. 3,2009Crownsville, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation MO1580 Services PA; 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEWMONIA DAYN /Medical Due to (or as a consequence of): **Examiner** ormunit punonary EMMA MNONE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Box 68760,8 Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, FIBRULATION NEPTALINFALET LETTHINK 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COMOBROVATALLAR autopsy MYTERPENSION 2-1 No 2 HO 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) HONT Hospital: 1∐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1-☑ Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ۵ 4 Homicide filled in 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) INTERN FUNT-GRAD YR 000 November 29, 2009 200 Cunto, M.P. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAINMORE TERMULO 3001 P. HANGLER ON MORSON MAPITAL M. D. CMERRIE 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Lawson WyaH 11:52 P M Sandra 5 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-58-6320 Months Days Hours Min. 1 □ M 2 1 F Director 4/21/1952 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show LIY or other traumatic event, It. It. Stout Exercite Items In Items I 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Woodlawn 1 ☐ Yes 2 No Director M Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA 2149 Streamway Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No African-American 2 Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Educator Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emice Alexander William Lawson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2149 Streenway Court, Woodlawn, MD 21207 Larange B. Watt/Husband 20a. Method of Disposition 1 Disposition 1 Disposition 3 Demonstrate 1 Demonstrate 2 D 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important; If it any injury or o 12-2-09 4 ☐ Donation 5 🛣 Other (Specify) Woodlawn cemetery Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wile funeral Home P.A. of Balto. Co. anague 9200 Liberty Road, Randallstown, M.) 21133 Part 1. Enter the disease, or complications that caus, d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sease or condition resulting in death) **←Physician** End. Stage lardiomyopallic /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Physician/Medical Examiner The law requires that the death certificate be executed ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has bi 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther Specify (P) 101/2 (P Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057465 11/25/09 impaliseM'D Reisenburg, MD. 21136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)_ Rajapalsemo 25 Main Sty 32. Registra s Signa 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NILLIAMS JOYCE 0908 A M 2009 NOVEMBED /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL RANDALLSTOWN BALTIMORE NORTHWEST If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 216-42-1926 1 M 2 X F Months Days Hours Min. **Director** 9-28-1946 63 MD Usual Residence of Decedent death with the Marviand 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience, ust be routiled at Director Y☐Yes 2☐No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2617 Garrett Avenue Funeral U 21218 SA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, 20 Wee Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2XNo Specify. <u>۾</u> Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygient Important: If Item 27 is marked other that any Injury or other traumatic event, Iral once. llth grade Disabled N/A Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Washington Reba Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 Upmanor Road Balto, MD 21229 Keith Brown-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Murial 2 Cremation 3 Removal from State Mt Carmel Cem 11-30-09 4 Donation 5 Dother (Specify) Balto, MD 21. Signature of Funeral Service License March East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter Le disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOMYOPATHY disease or condition resulting in death) SCHEMIC /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY Sequentially list conditions, many, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and burial-trar Due to (or as a consequence of): cate has been signed by the attending physiclan page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KIDNEY 1 Yes 2 No 3 Probably 4 Unknown DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifler Medical (Check only one)

P.O. Box 68760, Division of Vital Records. within 2

State

29b. Signature and title of

30. Name and address(of

31. Date filed (Month, Day, Year)

ALMED.

MURTUZA

Registra

COURT

OLD

person who completed cause of death (Item 23a) (Type, Print) 5401

29c. License number

RD,

D0060293

RANDAUSTOWN

29d. Date signed (Month, Day, Year)

2009

NOVEMBER

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Dav 240 PM William Williams 29 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Future Care Lochearn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 11/4/31 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Days Months Hours 1**X** M 2 □ F 216-30-5877 78 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show must be notified at Baltimore MD N/A1 XYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 21244 USA 9802 Plowline Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 ☐ Married ٥, 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced "natural"; American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Laborer the 12 Department of Health and Mental Hygie Important; If item 27 Is marked other any Injury or other traumatic event, ttonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Cumberland Lucy Ellis Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Park Vista Court, Woodstock, MD 21163 19a. Informant's Name/Relationship (Type. Print) Jackie Johnson/Guardian Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State nlace) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 12/1/09 Hanover, MD 21. Signature of Funeral 22. Name and Address of Facility Hari P. Close Funeral ervice Licensie 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onserand Death Immediate Cause (Final **Physician** Mischer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1 Yes 2 INo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 → Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA uneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

KAKEN 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

25 MACN METLILITT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

EISTERSTOWN

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** p^{M} 11 24 2009 Dorothy Rebecca Williams 8:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arundel 7680 Spencer Road Glen Burnie Anne 8. Date of Birth (Month, Day, Year) 08/22/1915 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Maryland 217-34-3272 94 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 21 No Director Anne Arundel MD Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21060 7680 Spencer Road U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: à Specify: 3 XWidowed 4 ☐ Divorced 'natural", Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Homemaker N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gaither Elizabeth ပ James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Williams (Daughter) 7680 Spencer Road Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, Germatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important; If ite any Injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 12/02/09 Glen Burnie, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, M Dietuchk N. Fulton Ave., Baltimore, MD 21217 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that controls shock, or heart failure. List only one cause on experience of the state Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Se Jentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence ot) certificate be executed ed by the attending physician and detached for use as the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I 9 Unknown certificate has been signed by rector, page 2 should be detach The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 2 140 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \sum Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

0 State

Registrar

title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed/(Month, Day, Year)

(Item 23a) (Type, Print)

32 Registrar's Signatu

🕽 🗠 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical

29a. Certifier

(Check only

29b. Signature and

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygieney for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nov. 2009 Year Frances Willoughby 22, 10:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manorcare Wheaton Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Months 1 □ M 2 🔀 F Hours Director 95 25, 1914 California 377-38-3392 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10h. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 Tx No Director MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mertal Hygiene. ant: If item 27 is marked other than "natural", or items 23a or uny or other traumatic event, I'm Nacioni Examiner must be. 8100 Connecticut Ave. #315 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Krutmeyer ၉ Charlotte Kirshen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Willoughby 3506 Center St., N.W., Washington, DC 20010 permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 25. 1 ☐ Burial 2 反 Cremation 3 ☐ Removal from State 2009 Chesapeake Crematory : Beltsville, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** Cardio-respiratory arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebrovascular disease Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (bras a consequence of) Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 □Yes 2 🙀 No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be o 2 HTN, history of colon cancer, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No glaucoma, hypothyroidism 24a. Was an this certificate has ral director, page 2 a autopsy perform 1 □Yes 2½ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 ☐ Pending investigation ours after death. neral Director: Af filled in by the fur 1 □ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral Di completely filled in 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55362 November 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Selya, M.D. 2101 East Jefferson St. Rockville, Maryland 20852 31. Date filed (Month, Day, 32. Registrar's Signature Year) State arked Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALICE WONG MD 10 NOETH GEFINE STREET BALTIMORE MD 2120) 31. Date filled (Month Day Year) 32. Registrat's Signature	1	Vithir Comp	Me	29b. Signature and	title of certifier							29d. Date	signed (Mont	h, Day, Year)	
ALICE WONG MD 10 NORTH GREENE STREET BALTIMORE MD 21201				AL	·W7	MD			P24	444		11/2	0/200	9	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a c 22 Per FH G898 12/08/09 JH and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician November 16, 200 258 Ruth Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner etimore aryland Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 🖾 F 220-16-7279 84 Oct. 19, Director 1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Miportant: If tiern 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, irs feating Examinating to notified a Baltimore 1X Yes 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2327 North Charles Street 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: black Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Holland Gladious Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth Holland/brother 6147 MacBeth Drive; Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 12/07/2009 Baltimore, MD 4 Donation 5 € Other (9 Metro Crematory Funeral Serv Rona La Name and Address of Facility Hone 11 Funeral Home 2120 4600 Liberty Heights Ave 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) neumonia spiration **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-1 attending physician Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 DNo certificate 1 ☐ Yes 2 ☐ No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this funeral 27. Mannet of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) mod manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed Division of Vital Records, To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

Baltimore,

Box 68760,

P.O.

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day,

32. Registrar's Signature

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician 1450 NalKer 2009 neresa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Maryland Medical Center

6. Sex 7. Age (In vis last hirth) Baltimore University of 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days -88-8749 1 ☐ M 2 🔀 🗏 Hours Marylan Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Eventinat must be notified at a longs. 10b. County 1 Xes 2 □ No saltimore Directo $\gamma \gamma a$ 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify: Blac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nalker ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Pelationship (Type. Print) Ba Sharon morel Walker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature uneral Servi e Live ee march 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate or use (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner 24 hours Hemorrhage Intracerebral Massive Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 □Yes 2 No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 No 2 **Z**No 1 Tyes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth 31. Date filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature and title of certifier

M.

Crandall Registrar's Signature

and manner stated.

22 S. Greene

MI

29c. License number

19900

Bultimore

29d. Date signed (Month, Day, Year)

Nev

2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Walters Month 29 Day 2009 8:35 P M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days 89 3/8/1920 Director 213-01-2981 Usual Residence of Decedent or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6502 North Charter Rd. #L 21061 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 XDivorced Specify White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Highway Administration Electrician Be other traumatic event, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Walters Edith Mumma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Walters/daughter Ruxview Ct. #202 Towson MD 21204 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 12/3/09 Other (Specify) New Cathedral Cem. Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) PROSTATE CANCER Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) anding physician a use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director, After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No Yes 2 X No of Vital Certificate: To Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes 2X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗶 Natural injury work?
1 Yes Division 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar

JOVEMBER

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JENNIFER HAUF

31. Date filed (Month, Day, Year)

K157629

TIMONIUM, MD 21093

11/30/2009

State of Maryland / Department of Health and Mental Hygie 2e 0 9 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 13 Day **Physician Alvin Watkins** 9:45 AM NOV 2009 /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/A Levindale Hebrew Genatric Center & Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 24, 1972 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X**0 M 2□ F 217-17-5144 36 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Randallstown Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with U.S.A 21133 47 Horseman Court or Itame 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 K Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Black Specify 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Hilton Hotel Elementary/Secondary (0-12) College (1-4or 5+) Chef 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of Deborah Watkins Alvin Watkins Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 47 Horseman Court Randallstown, Maryland 21133 Deborah Watkins Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State ō Lansdowne, Maryland Department of Important: If any injury or once. 11/19/09 Mt. Zion Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the Jeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Death Immediate Cause (Final brain ini multiple trauma 3 yrsand 4 mon Traumatie Physician resulting in death) /Medical 3 485 and 4 month Examiner vehicle motor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 일 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Patient was 28a. Date of Injury (Month, Day Year) Certification: thrown away from his motor bike 1 Natural 5 Pending 11:00 PM 1 Yes 2 No July 29,2006 we to an unmarked raised surface investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Patapsec Avenue, Baltimore, MD 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13,2009 D0053928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURAIYA BEWUM, MD 2434 WIBELVEDERE AVENUE, BALTIMORE MD -MD , BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/200

/Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ed by the page 2 s or Attending Physician: filled in by within 24 hours a

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or

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s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth

Pages 1

permit. Page Department o Important: If any Injury or

Physician

If item 27 or other t

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Be Completed

Certification: To

Medical

State Registrar

MD

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

in the past 12 months? 1 ☐ Yes 2 【X No 9 ☐ Unknown		topic pregnancy her (specify)		Month Day Year
Part II. Other significant conditions of Work Hoologics:	contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	ise contribute to the cause of death? No 3 Probably 4 Unknow
	•		24a. Was an autopsy performed? 1∐ Yes 2 ½ No	24b. Were autopsy findings availabl prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	3 DOA Other: 4 Nursing	Home 5 ☐ Residence	Assisted
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred Living
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
29a. Certifier 1½ CertifyIng Ph (Check only one) 2 ☐ Medical Exar	niner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place tigation, in my opinion, death occ	ce, and due to the cause(s) curred at the time, date and	and manner as stated. If place, and due to the cause(s)
29b. Signature and title of cen fier	~~	29c. License number 022856		te signed (Month, Day, Year)
30. Name and address of person who	completed cause of death (Item 23a) (Type, Prin		They (done	Gra Mad 21044
31. Date filed (Month, Day, Year)	009 32. Registrar's Signatura	Kal		

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Pstate by Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 450M 4a. Facility Name (If not institution, give street and number) Philip Witkus /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 21 Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign **Funeral** Months Days Hours Min 2□ F 6-16-985 PA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD 10e. Street and Number 10g. Citizen of What Country? Of, Zip Code 500 N. MArlyn Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Beth Steel 12th is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental John Witkus Veronia Vengis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Loretta Thompson/daughter 9028 Fieldchat Road Baltimore MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridga Cemetery 11/17/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signalufe of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -Metastas 3 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 □Yes 2 □ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed: autopsy 2 110 1 □ Yes or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 Accident 2 □ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11/14/2009 M.D. D0069314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prajapati, M.D. Mittal Rd, Parkville MD 21234 Woods Waltham 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		•	1 - State Of Market State Of M	,	tificate of Death	Nientai Hygii	g. No 2009	38170
	Physici	an	1. Decedent's Name (First, Middle, Last)	W:	lson	2. Date of Death		3. Time of Death
T	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	h
To go			The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	Baltimore City If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birt	hplace (State or Foreign
i	Funeral Director		1 TM 2 TE	73 Yrs.	Months Days Hours Min.	(Month, Day, Y	(ear) Co.	untry)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Maryli a-f sho jied at	tor	MD n/a	Balt	imore			1 Yes 2 No
	with the	Il Director	10e. Street and Number 1211 Ensor Street		10f. Zip-Code 21202	10	g. Citizen of What Cor USA	untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1	No.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify: X	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	e, etc.
21215-0036	tural",		15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business/	ack /Industry
212	ithin 72 e. an "ne Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	life	kind of work done during most of wo DO NOT use retired)		Construct	tion
121	filed with Hygiene. Ather than		unk. 17. Father's Name (First, Middle, Last)	Heav	y Equipment Op	erator me (First, Middle, N	Construct Maiden Surmame)	210n
Maryland	ould be f Mental H arked of atic ever	To Be	Reynolds		Mary	Wilson		
ary	2 should be and Mental is marked c aumatic eve		19a. Informant's Name/Relationship (Type. Print)	/.1	ng Address (Street and Number or R			
Z,	1 and 2 Health a em 27 is ther tra		Mary Wilson (daughter)		2 W. Lexington		1 to, Md.	21223
	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition ★□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Mt. Zio	osition (Name of matory or other place) n Cemetery Dec	.4,2009	Baltimo	
Balt	permit. Pag Department Important: I any injury o		21 Innature of Funeral Service Licensee	C C	2. Name and Address of Facility alvin B. Scrug	gs Fune:	ral Home	
	20200		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lime mediate Cause (Final	the death. Do not en	412 E. Preston ter the mode of dying, such as cardia	St. Ba	lto,Md.	21213 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	iple M	ycloma			Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as	a consequence of):	en Disease			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):				
ely	uted d ransit	Examiner	Cause (Disease or injury that initiated events c.	gestive	Heart Failu	re		
0	icate be executed physician and is the burial-transit		resulting in death) Last Due to (or as	a consequence of):				
8760,	physic physic s the b	ledical	d					
P.O. Box 6	death certif e attending ed for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
	The law requires that the tee has been signed by the page 2 should be detach	þ	Part II. Other significant conditions contributing to death	out not resulting in the	underlying cause given in Part I.	23e. Did tob	oacco use contribute to	robably 4X1 Unknown
cor	w requ	Completed				24a. Was an autopsy	y prior to	utopsy findings available completion of cause of
E E	The law ate has I page 2	Som				perform 1 🗆 Yes 2	ned? death? 2 No 1 ☐ Yes	
Vita	ysician; Th s certificate director, pa	Be	25. Was case referred to medical examiner?		Othor	ath (Check only one		-16.0
o	× 00 0	<u>ان</u>	27. Magner of Death 28a. Date of Inju	iry 28b. Time o	of 28c. Injury at		nce 6 Other (Spe ow injury occurred	Спу)
ion	nding ath. r: After	atior	Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	I or Attending after death. Director: After d in by the fune	Certification:		ury - At home, farm, st c. (Specify)	reet, factory, office	28f. Location (St. City or Town,	reet and Number or F , State)	ìural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical Co	29a. Certifier 1 X Certifying Physician: To the best (check only one) 2 Medical Examiner: On the basis on and manner s	of examination and/or in	th occurred at the time, date and place	e, and due to the co curred at the time, d	ause(s) and manner a late and place, and du	is stated. ue to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier		29c License number		9d. Date signed (Moni	
b	7		I D. Dough & Short		RES-000		November	25,200
	7		30. Name and address of pirson who completed cause of Douglas Gilbert		600	North Wol	fe St, Baltim	ore, MD, 21287
	Sta Regist		31. Date filed (Month, Day, Year) DFC 0 1 2009	ar's Signature	ukol			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** - 200 Watkins III Harrison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Overlea Nuring and Rehabilation Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 → M 2 □ F 214-56-5613 57 Director May 21,1952 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show the Medical Examiner must be notified at Baltimore MD n/a 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 127 Arlington Ave.Apt.608 21217 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Spec#Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bowie State 10thCustodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Harvey Nathan Watkins ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Joppa, MD 21085 Barbara Watkins (wife) 703 Jonathan Dr. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery Dec.1,2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Calvin B. Scruggs Funeral Home ignature of Funeral Service Licenses Preston St. Baltimore, Md. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner onolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a obnsequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 XNatural 2 ☐ Accident ours after death.

leral Director: A
filled in by the fu death. 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Box 68760, Division of Vital Records. within 24 hours a

To the Funeral C

completely filled

> State Registrar

29b. Signature and title of certifier,

31. Date filed (Month, Day,

Ulm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601-

32. Registrar's S

25391

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19b, per Fh 9899 12/1/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 29 2009 DORRIT WESTHEIMER 4:34P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner BALTIMORE** 8002 BRYNMOR COURT, #503 BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 💢 F Months Days Hours 271871936 CZECHWREPUBLIC Director 161-28-2219 73 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 Yes 2 X No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8002 BRYNMOR COURT, #503 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. "natural", or 1 Never Married 2 Married Š Bestimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ FEUERSTEIN MARIANNE ROBITSCHEK EDMUND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau RACHEL BLOOM / DAUGHTER BELLEMORE ROAD, BALTIMORE, MD. 21208 21210 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ZTON OF place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/30/2009 RANDALLSTOWN, MD 21. Signature of Euperal Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one rause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 2006 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 12MOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or immer) Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 IF FEMALE: . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director:
completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a Certifie riving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Framiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QJANKY

DHMH 17 Rev 7/2009

State Registrer 31. Date filed (Month, Day, Year)

			For State of I	Maryland / Depa <i>Cer</i>	artment of H	ealth and M eath	lental Hygio	ene 2009	38173
	Physicia		Decedent's Name (First, Middle, Last) DIANA BERYL WEINBERGER				2. Date of Death	26° 2009	3. Time of Death 11:15P M
-	Medio Examin		4a. Facility Name (if not institution, give street and number GILCHRIST HOSPICE CARE		4b. City, Town, or TOWS	Location of Death		4c. County of Dea	ath
	Funeral Director		218-32-7412 1 M 2 X F	Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 09/23/19	9. Bi Co	rthplace (State or Foreign ountry) NY
	Maryland :8a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE	10c. City, Town or Loc	cation				10d. Inside City Limits 1 ☐ Yes 2 💢 No
	ith the 8 23a or 2 st be no	ral Di	10e. Street and Number 9050 IRON HORSE LANE, #114		10f. Zip Code		10	g. Citizen of What C	ountry?
920	s filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give	t Ever in U.S. 13. V	21208 Was Decedent of His f Yes, specify Cubar □ Yes 2 1 No	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0	vithin 72 hours giene. er than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 of 5 +	(Give k	dent's Usual Occupa kind of work done du O NOT use retired) TEACHER	tion uring most of worki	ng 1	6b. Kind of Business	,
yland ;	0 40 0	To Be	17. Father's Name (First, Middle, Last) DAVID DUCAT			18. Mother's Name	e (First, Middle, Ma	iden Sumame)	COHEN
Baltimore, Maryland 21215-0036	and 2 sh Health ar tem 27 is		19a. Informant's Name/Relationship (Type, Print) MARVIN WEINBERGER/HUSBAND 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	9050 20b. Place of Disposerentery, crem	IRON HORS	E LANE,	#114 BA	LTIMORE. Oc. Location - City of	MD 21208 r Town, State
Baltır	permit. Page 1 Department of Important: If i any injury or o		4 Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee	22	. Name and Address	11/29, s of Facility SOL ERSTOWN F	LEVINSON	NDALLSTOW & BROS., ESVILLE.	
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that daus shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition resulting in death) Due to (or a	d the death. Do not ententente. Jecuitarian s a consequence of:		, such as cardiac o		,	Approximate Interval Between Onset and Death
09	certificate be executed inding physician and use as the burial-transit	dical Examiner	Cause (Disease or linjury that initiated events	s a consequence of):					
Š 2	death ne atte ed for	Physician/Med		n 2 🗌 Fetal death 3 🗀 t at time of death 5 🗀	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
JS, P.O	uires that the in signed by th	by	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	L4 -	o the cause of death? Probably 4 🔲 Unknown
l Kecords,	n: The law rec ficate has bee vr, page 2 sho	Completed	25. Was case referred to medical				24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Division of Vital	To the Hospital or Attending Physician: The law requires within 24 hours arier death. To the Funeral Director After this certificate has been sign completed filled in by the funeral director, page 2 should be	Certificate: To Be	examiner? 1 Yes 2 No Hospital: 1 Inp. 27. Mapner of Death 1 Natural 5 Pending 2 Accident Investigation	atient 2 ER/Outpatien jury 28b. Time of injury	ot 3 DOA Other 28c. Injury work?	at Nursing Hol	St. Letter	ce 6 Other (Special Injury occurred	cin Gilchast
DIVISI	ital or Atte urs af er de ral Directo lled ir by th		building,	njury - At home, farm, stre etc. (Specify)			City or Town, S		
	the Hosp ithin 24 hor the Fune ompleted fi	Medical	29a. Certifier (Check only one) 3 □ Certifying Physician: To the best of the control of the co	examination and/or investi	igation, in my opinior	n, death occurred at time, date and place	the time, date and pe, and due to the ca	place, and due to the	cause(s) and manner stated. s stated.
D	⊢ ≶ ⊨ ő		Der Ball 1	N	06	2018		11/27/0	9
			30. Name and address of person who completed cause of the Ray Market Market (Month, Day, Year) 32. Rec	death (Item 23a) (Type, Pi	cres s	P, Sui	Pe 410	5, Balt	simone MS
	Stat Registra		DEC 0 1 2009	trar's Signature	park			l	,

09-09080 Ro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

nald Woodall	1		rtment of Health and Mental Hy tificate of Death	ygiene Reg. No	200	9 3817
Physicia	F	tegistrar 1. Decedent's Name (First, Middle,Last)	imode of Bodi.	2. Date of Death	3	. Time of Death
edical Examir		RONALD ROY WOODALL		Month Day November 22,		0805 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Bel Air		c. County of Death Harford	
		Upper Chesapeake Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. la			WDD/YYYY) 9. Birthp	place (State or
Funeral Director			Months Days Hours Min		Foreign	West ^{try} Virginia
		214-44-9979 1x M 2 F 62	113.	Sep. 17,		
any			Town or Location		1	0d. Inside City Limits 1 Yes 2 Mo
and I show	ō	Maryland Harford Bel	Air	140- 0	itizen of What Countr	
ie Maryland or 28a-f show any fied at once.	Director	10e. Street and Number	10f. Zip Code 21015	1	JSA	,
with the Maryland ms 23a or 28a-f sho be notified at once,		2346 Pennington Road 11. Marital Status 12. Was Decedent Ever in U.	S 13 Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - America	an Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
ufter de	면 된	1 X Yes 2 No 3 Widowed 4 X Divorced of Fyes, Give Yeer or Dates:	1 Yes 2 X No specify:			ite
hours afte 'natural", Examiner	ed b	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done [16b tired]	. Kind of Business/Ind	dustry
36 thin 72 te. thau "1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Contractor	T.	Home Impro	vement
d with ygiene ther t	ĕ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide		Vallatie
21215-0036 Mental Hygiene. marked other than 'c event, the Medical	Be	Roy Walden Woodall	Alleynie	Virginia_	Mullens	7.0.13
C 7 2 4 2	٤	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or			
, MD and 2 sho ealth and em 27 is		Eva I. Simmont / Companion 20a. Method of Disposition 20b.	2346 Pennington Road Place of Disposition (Name of cemetery,	Date 20	c. Location - City or T	own, State
altimore, mit. Pages I ar partment of He portant: If ite		Aburiai 2 Cremation 3 A Removal from state	crematory or other place) ex Williams Cemetery 11	_27_00 C	amdon on G	auley WV
nit. Pa artmer oortan		4 Donation 5 Other Specify: ALE 21. Signature of Funeral Service Licensee	22 Name and Address of Facility McComas Funeral H	Iome. P.A.	allocii on o	autcy/ WV
Dep Den	1 8	Stepley allege	1 1317 Cokesbury Ro	oad. Abingo	lon, Maryl	and 21009 Approximate Interval
Physician Madic J		23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.		or respiratory arrest, s	snock, or near	Between Onset and Death
xaminer	i	mmediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosci	lerotic Cardiovascular Disease			
		Sequentially list conditions, b.				
	iner	if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of	of):			
.=	Examiner	(Disease or injury that initiated events resulting in death) Last	of):			
50, te be executed ysician and burial - transit		d				
O, e be ex ysician burial	ledical	UNPENDED AMENDED			23d. Date of delivery	
Sox 6876 Jeath certificate e attending phy I for use as the I	M/us	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months?	2 Fetal death 3 Ectopic preg			ay Year
Box 6876 death certificat the attending ph	Physician/M	4 Pregnant at time of d 1 Yes 2 No 9 Unknown g Unknown	eath 5 Other (Specify)			
by the oched f	Phy	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.		cco use contribute to	
ires that the signed by I be detached	d by	hypercholesterolemia		1 Y Yes	2 No 3 Prob	
ords, w requir us been s	lete			24a. Was an autopsy	prior to o	topsy findings available completion of cause of
eco he law ate has	Completed by			performe 1 Yes 2		es 2 No
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been is led in by the funeral director, page 2 should I	Be C	25. Was case referred to medical examiner?	26.Place of Death (Chec		sidence 6 Other	-
f Vit Physic or this c	일	1 Yes 2 No	ER/Outpatient 3 DOA Other Nur 28b. Time of Injury 28c. Injury at Work?	sing Home 5 Re		
in of viding Ph. th. After the funeral	<u></u>	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	1 Yes 2 No			
risior r Attend er death irector:	licat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, street, factory, office building, etc.	28f. Location (Street		ıral Route Number, City
Divi pital or ours afte eral Dir	Certification:	4 Homicide determined (Specify)				
		2ga. Certifier 1 Certifying Physician: To the best of my knowle (Check only one)	edge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurre	and due to the cause(sed at the time, date and	s) and manner as stat d place, and due to the	ed. ne cause(s)
To the Howithin 24 P. To the Funcompletely	Medical	29b. Signature and the of certifier	29c. License number		29d. Date signed (Mo	
	-	1 6 / f 6 / f 6	O.C.M.E.		November 22, 2	009
		30. Name and address of person who completed cause of death (Ite	em 23a)			
		Victor Weedn MD JD Assistant Medical Exam		1D 21201		
S Regis	tate	0000 6	A barles			
DHMH 17 Rev 1/		UEU 1 cous / Consum	ORIGINAL			
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	,	1 - State Registrar	State of Ma	aryland	d / Dep <i>Ce</i>	ertificate of l	lealth a D <i>eath</i>	and Mei	ntal Hyg R	giene , Reg. No. 4	2009	38175
_ Physici	an	1. Decedent's Name (First, Middle, La		<u> </u>					Date of Dear		20Y885	3. Time of Death
/Medi	cal	William August Wiedenhoeft 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							ovembe	ber 25, 2009 5:5		5:50 P M
Funeral Director	ier	Esther's Place 5. Social Security Number 6.	Assisted		ng ast birthday Yrs.	Hamilto		24 Hrs 0	Date of Birth (Month, Day		O Birt	hplace (State or Foreign unity) ryland
		Usual Residence of Decedent 10a. State 10b. County			, Town or L	continu				,		10d. Inside City Limits
Maryla f sho	ro	,				.ocation						1 ☐ Yes 2 ☐ No
h the l	Director	Maryland Harford 10e. Street and Number		DET	Air	10f. Zip Code			1	I0g. Citizer	n of What Co	untry?
ath wit		1622 Cass Driv	1			21015				USA		
partitione, Maryland ZIZISJOSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show way hijury or other traumatic event, the Model Evariant must be notified at once.	by Funeral	Never Married 2 Married Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		5. 13.	. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🙀 No	ispanic Orig in, Mexican, Specify:	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)		Race - Ame Black, White Decify:	
2-UU30 72 hours aff natural", or	eted	15. Decedent's E (Specify only highest gr	ducation		16a. Dec	edent's Usual Occup	ation	t of working		16b. Kind	of Business/	
within within and than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retired	()	or working		D		
illed v i Hygie other i	Be Co	17. Father's Name (First, Middle, Las.	')	l	BOOK	<u>Binder</u>	18. Mother	r's Name <i>(F</i>	irst, Middle, i	<u>Print</u> Maiden Su		
uld be Wenta	To B	August (nmn) Wi	edenhoeft				Mary	(nmn)) Otre	mba		
Viar		19a. Informant's Name/Relationship				ling Address (Street						•
1 and 1 and Healt tem 27		Joan Strickroth 20a. Method of Disposition	/Daughter	20b. PI		2 Cass Dri position (Name of ematory or other place		el Ai			2101 tion - City or	
antimor mit. Pages partment of portant: If it y Injury or og.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont		į			i	12-1-0				
emit. epartr poorta ny Inju		21. Signature of Funeral Service Lice		HIL	I TOP	Service C	orp: ne al	y Home	, P.A.		on, Ma	ryland
6 8 8 6 8		Siglin U.I.	legis		1	1317 Cokes	bury :	Road,	Abing	don,	Maryl:	
Physician	k n	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ie.	. Do not er	nter the mode of dyin	ig, such as o	cardiac or re	espiratory arr	rest,		Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as		ence of):							Years
Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as									
uted 5 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
rou, te be exec /sician and e burial-tra	Exa	resulting in death) Last Due to (or as a consequence of):										
cate b	edical											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral after death. To the Funeral infer the theorem of the property of the property of the property of the property of the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗀 Fetal	death 3	☐ Ectopic pregnancy	у			230	I. Date of del Month	ivery Day Year
w requires that to been signed by should be detail	by	Part II. Other significant conditions	inificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use							use contribute to the cause of death?		
The law recate has bee bage 2 shou	Completed							[24a. Was a autops perform	med?	prior to death?	utopsy findings available completion of cause of
Of VICAL PROPERTY OF PROPERTY OF THE REPORT OF THE PROPERTY OF	Be	25. Was case referred to medical examiner?	10			12	_	of Death (C	heck only on			
Physical direction	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of Injur		ER/Outpatie	of 28c Injury	4 ∟ Nui		5 Reside			Living
nding ath. :: Afte e fune	ation	1 ■ Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day	(, Year)	Injury	Work	(? Yes 2 □ N		. Describe in	OW IIIJuly O	courred	niving
Lai or Atte safter deg	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injubulding, etc	iry - At hoi :. (Specify	me, farm, st	treet, factory, office		28f.	Location (Si City or Town	treet and N n, State)	lumber or Ru	ural Route Number,
he Hospi in 24 hour he Funer pletety fill	Medical	29a. Certifier 1	hysiclan: To the best of mlner: On the basis of and manner sta	examinat	wledge, dea tion and/or i	ath occurred at the tir investigation, in my o	me, date and pinion, deat	d place, and th occurred	due to the cat the time, d	cause(s) ar date and pla	nd manner as ace, and due	s stated. to the cause(s)
Veith To t	Σ	29b. Signature and title of certifier				29c. License			2			h, Day, Year)
		30. Name and address of person who	71	anth /P - :	00-) (7	1)311	195			11/	27/09	
		Wendy Clorsz		2	1/1	1 0	1300	4 ~	70 21	206		
Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	ır's Signat	ure And	adel						

DHMH 17 Rev 1/2001

09-08863 Magdeline Zeiters

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 38176

		For State	Certificate of		Reg. No.	La Time of Booth
Physicia dical Examir	n/ ner	Decedent's Name (First, Middle, Last) Madgeline	Zeiters		2. Date of Death Month Day November 15, 2	Year 0808 hrs County of Death
	4	la. Facility Name (if not institution, give street at 1044 Arion Park Road #124	nd number)	4b. City, Town, or Location of Death Catonsville		altimore County
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/D	DD/YYYY) 9. Birthplace (State or Foreign
Director		219-108-9334 1 M 25	51 Yrs	Months Days Hours Min.	Dec 17, 1	957 Country) Maryland
A		Jsual Residence of Decedent	10c. City, Town or Local	tion		10d. Inside City Limits
ow any	1	10a. State 10b. County		erview_		1 Yes 2 No
ryland sa-f sho	황	HIS DOFO) 111 VC	10f. Zip Code	10g. Citiz	en of What Country?
the Ma n or 28 lifted a	Director	12011 Cedarfix	eld	33579		USA
ms 23s	ral	11. Marital Status 12. Wa	as Decedent Ever in U.S. 13. Waned Forces?	as Decedent of Hispanic Origin? (Spores, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
er death	핊	Never Married 2 Married 1	Yes 2 No	Yes 2 No specify:		Specify: White
Imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If iem 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	ğ.	3 Widowed 4 Divorced or Pates 15. Decedent's Education (Specify only higher	et grade completed) 16a Decede	nt's Usual Occupation (Give kind of w	rork done 16b. h	find of Business/Industry
72 hou	Completed	Elementary/Secondary (0-12) Coll	ege (1-4 or 5+)		60)	Rotall.
5-0036 led within 7 Hygiene. other than	<u>ق</u>	17. Father's Name (First, Middle, Last)		ashier 18.Mother's Name	(First, Middle, Maiden	Surname)
e filed lal Hyg ked oth	Be C	Linknown		unl	Lnown	
2121 ould be fil d Mental I s marked lic event,	입	19a. Informant's Name/Relationship (Type, Prin	"' 1 1 1 1 1 1	ng Address (Street and Number or F	Rural Route Number, C	ity or Town, State, Zip Code) KI VELVIEW, FL 33579
, MD 21215-003 and 2 should be filed with fealth and Mental Hygiene tem 27 is marked other to traumatic event, the Men		Shamika Leiters 20a. Method of Disposition	-daughta 120	osition (Name of cemetery,		Location - City or Town, State
Ore, es lar of Hez If ite			crematory or c	other place)	27/09 E	Baltima min
		4 Donation 5 Other Specific 21. Signature of Funeral Service in entire	PICTYC	Name and Address of Faility	WIPLI FIL	miral Home
Balt permit Depart Impor injury	1	March & No	well Sl. 14	600 Liberty He	ights Au	e; Balto MD21207
Physician		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.	that caused the death. Do not enter	the mode of dying, such as cardiac c	r respiratory arrest, sh	Approximate Interval Between Onset and Death
Modical aminer		Immediate Cause (Final disease a. Hy]		ovascular disease		Deatil
		h	or as a consequence of):			
	횰	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	(or as a consequence of):			
	Examiner	(Disease or injury that initiated C.	(or as a consequence of):			
ecuted and - transit		d				
760, cate be exe physician he burial	//Medical	7. 5		rmE, g898 12/10/0	9 TT	3d. Date of delivery
	W/W	23b. Was decedent pregnant in the		Fetal death 3 Ectopic pregn		Month Day Year
Box 687 e death certific the attending p	siciar	past 12 months? 1 Yes 2 No 9 V Unknown 9	Pregnant at time of death 5	Other (Specify)		
o.O. Bc that the der ned by the a detached fo	Phys	Part II. Other significant conditions contrib		e underlying cause given in Part I.		o use contribute to the cause of death?
, P.O rres that to signed by	۾	Acute renal failu			1 Yes 2	No 3 Probably 4 ✔ Unknown
ords, w require us been s should t	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
eco he law ite has	ᇤ				performed' 1 Yes 2	death? No 1 Yes 2 No
tal Rectian: The	Be	25. Was case referred to medical examiner?		26.Place of Death (Check		0 -
Division of Vital Records, tal or Attending Physician: The law require as after death. Director. After this certificate has been siled in by the funeral director, page 2 should the	일	1 ✓ Yes 2 No	Impatient 2 Erocupation	elit e Ben	ing Home 5 Resi	dence 6 Other: Scene
n of ding PI h. After	Ë	27. Manner of Death 1 X Natural 5 Pending	Sa. Date of Injury (Month, Day,Year)	1 Yes 2 No		
isio Atten er deat rector	iz	2 Accident Investigation	8e. Place of Injury - At home, farm, s	treet, factory, office building, etc.	28f. Location (Stree or Town, State)	and Number or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined	Specify)			
Hosp 24 ho Fune etely f		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, death of	ccurred at the time, date and place, ar igation, in my opinion, death occurred	nd due to the cause(s) I at the time, date and	and manner as stated. blace, and due to the cause(s)
To the within To the To the comple	Medical	one) 2 Medical Examiner: On the and modern 29b. Signature and title of certifier	nanner stated.	29c. License number		d. Date signed (Month, Day, Year)
	2	290. Signature and fitte or continu	0.10	O.C.M.E.	N	ovember 15, 2009
almer		30. Nam and address of person who complete	ed cause of death (Item 23a)			
ONTY			ant Medical Examiner 11	1 Penn Street, Baltimore, MI	D 21201	
	State	THE PARTY OF THE P	32. Registrar's Signature	ela)		
Regi		UEL (I LAND /	ORIGII			
DHMH 17 Rev 1	12001	OCME	ORIGII			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Ashwood State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day November 4, 2009 1648 hrs Medical Examiner Robert Marian Ashwood 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director Hours Country) Virginia 79 1 X M 2 F Yrs 06/07/1930 229-26-9675 Usual Residence of Decedent 10a State any 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No or items 23a or 28a-f show MD Anne Arundel Friendship Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
anti: If (tiem 27) is marked other than "natural", or items 23a or 28a-f she or other trawnarie event, the Medical Examiner must be notified at once. irector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7010 Prout Road U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 1X Yes 2 No If Yes, Give Year 1948-1953 3 X Widowed Divorced Specify: White Yes 2 X No specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Itimore, MD 21215-0036 C&P Telephone Manager 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Ashwood Mabel Pitcock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print.) Vincent C. Scott (Bro.-in-Law) 6207 Nethercombe Ct., McLean, VA 22101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 11/16/2009 Falls Church, VA National Memorial Park 4 Donation 5 Other Specify. 22. Name and Address of Facility Murphy Falls Church Funeral Home ignature of Funeral Service Licensee 1102 W. Broad St., Falls Church, VA 22046 ann Approximate interval **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line /Medical a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and or use as the burial - tran Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed peen 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed Yes 2 V No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Other₄ Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 this Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Director: 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) hin 24 hours a the Funeral I npletely filled determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. November 9, 2009 30. Name and address of person who completed cause of death (Item 23a)

6

State Registra

Russell Alexander MD.

32. Registrar's Signature

Assistant Medical Examiner

OCME

111 Penn Street, Baltimore, MD 21201

B, yeese MOOY8

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

Immediate Cause (Final

	For	State of i	viai yiaili	i / Depai	runeni oi nea	aith and iv	іенкаі пу	giene				
	1 - State Registrar		_	Cert	tificate of De	eath		Reg. No. 2	2009	3817		
	1. Decedent's Name (First, Mic	ddle, Last)					2. Date of De			3. Time of Death		
an al	ELIZABE	TH M	47	BRI	WE		NoV.	OI,	2009	5: 17PM		
er	4a. Facility Name (If not institut	ition, give street and numb	en		4b. City, Town, or Loc	cation of Death		4c. Co	ounty of Death			
	HOWARD COUL			SPITTE	COLUN				HOWA	-		
	5. Social Security Number 218-54-5058		Age (In yrs. I			Under 24 Hrs. lours Min.	Aug I	8 193	9. Birthp Coun Mary	lace (State or Foreign stry) Land		
	Usual Residence of Decedent				,							
	10a. State 10b. Cour	nty	10c. City	, Town or Loca	ation		. <u>. </u>	10d. Inside City Limits				
ctor	Maryland Ann	e Arundel	S	evern						1 □ Yes 2 🛣 No		
ire	10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?					
a D	8025 Old Mi	11 Ct.		21144			USA					
Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes, Give Year or Dates:			n U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 □Yes 🏋 No Specify:				ecify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black				
leted	15. Deced (Specify only high	dent's Education thest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			ng	16b. Kind of Business/Industry				
μ	Elementary/Secondary (0-12	2) College (1-4e	or 5+)		,							
ŏ	11th	0		Hou	Housewife			None				
Be (17. Father's Name (First, Middle	lle, Last)		18. Mother's Name (First, Middle, Maiden Surname)								
To B	Arthur Will:	iams	Rosie Edwards									
	19a. Informant's Name/Relatio	onship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	Cheryl Williams(Niece)				8025 Old Mill Ct. Severn, Md. 21144							
	20a. Method of Disposition		20b. Pl	ace of Disposition (Name of Date emetery, crematory or other place)			ate	20c. Loca	tion - City or To	wn, State		
				aryland Veteran 111-10-09 Crownsville,					e, Md.			

Physician /Medical

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau
once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

and Mental Hygiene.

Baltimore, Maryland 21215-0036

injury or other traumatic event, the Medical Examiner must be notified at

28a-f show

Examiner

disease or condition resulting in death) Due to (or as a consequence of): SHOCK SEPTI4 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) ABSCESS PELVIC resulting in death) Last Due to (or as a consequence of): Physician/Medical DUST CONMITION SURGICAL IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

PNEUMONIA

To the Hospital or Attending Physiclan; The law requires that the death certificate be executed physician and the burial-trans P.O. Box 68760, Division of Vital Records, After this neral Director; A within 24 hours after To the Funeral Direc

10

State Registrar

Medi

29a. Certifier

(Check only one)

29b. Signature and title of certifie

STENDING PHYSICI AN

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

821 West St. Annapolis, Md. 21401

Winname Rowages of EaciliSons Mortuary,

050404

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

NOV.

10632 LITTLE PATRIXENT PLANY \$14 COLUMBIA, MD 20044

Month

Approximate Interval Between Onset and Death

5 DAYS

Year

Day

1 ☐ Yes 2 KNo

. Name and address of pe	erson who con	npieted cause of death (ite	em 23a) (Type, Print
ALKESH	D.	PATEL	10632 L

PATEL 32. Registrar's Signature

31. Date filed (Month, Day, Year) NOV 1 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:17AM Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince George's Bowie 4106 Whitney Ct. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Sept. 13, 1951 Months Days Hours Min. 1 M 2 F California 58 Yrs 220-46-3242 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 23a or 28a-f show 10c. City, Town or Location 10a. State and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho **Funeral Director** 1 AYes 2 □ No Prince George's Bowie MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20715 4106 Whitney Ct. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. Yes Give White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Insurance Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Natalie Kernan Belden ည Stephen B. Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4106 Whitney Ct. Bowie, MD 20715 Chris M. Hazell / Partner 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 11/10/2009 Baltimore, MD Bayview Crematory 4 Donation 5 Other (Specify) Beall Funeral Home 22. Name and Address of Facility 21. Signatura of Furreral S Bowie, MD 20715 6512 NW Crain Hwy. Approximate Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the failure. List only one cause on each line. Immediate Cause Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) signed by the attending physician and does be detached for use as the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Year in the past 12 menths?
1 Yes 2 No
9 Unknown Month Day 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗐 No 3 Probably 4 Unknown page 2 should be 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has performed? Yes 2 \(\sigma\) No death' 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify ဂ္ 1 Yes 2 00 No 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after To the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29h. Signate wen, NH Who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month strar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 38180 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ NOVEMBER Day 2009 RUBY KAMSCH BROWN 7:58 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1606 STERN COURT ANNAPOLIS ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month Day, **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F MARCH 29, 1921 Director VIRGINIA 88 220-14-9678 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1606 STERN COURT 21409 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ☐ Yes 2 X No b 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 🕱 Widowed 4 🗆 Divorced Specify: WHITE Completed th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 INSPECTOR **DEFENSE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ JAMES KEMP RUBY RILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA HOFFMAN/DAUGHTER permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti 1606 STERN COURT, ANNAPOLIS, MARYLAND 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State PROVIDENCE BAPTIST CHORCH NOVEMBER 14
CEMETERY 2009 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAYES, VIRGINIA Signature of Funeral Service License FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Sugar and Death Immediate Cause (Final Physician/ ans years disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury within 24 hours after death.

To the Funeral Director: Aft 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific \sim 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chambes MD 31. Date filed (Month 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 10 2009 8:55 PM Lucille Bruce /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery County Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 5 F 85 08-17-1924 No.Carolina Director 245-48-8641 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 273 is marked other than "natural", or items 23a or 28a-5 show any hijury or other traumatic event, its Macien Examines must be notified any hijury or other traumatic event, its Macien Examines. Washington, D.C. DC Director M Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20019 4800 East Capitol St., N.E. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2**∑** No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 **Black** 1 ☐Yes 2 ☐No Specify: 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Waitress 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pinkey Lee Buzzar Lee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20019 James Cooper (Son) Washington, D.C. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 11-17-2009 Suitland, MD 21. Şignatur ol Fymeral Service Licenses 22. Name and Address of Facility Ralph Williams, II Funeral Service, P.A. 5202 PrincetonsDelightDr.Bowie,MD 20720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician mma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After, this certificate has been signed by the attending housing and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnant Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ₹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 4 nknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐Yes 2 ☐No Division of Vital 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 □ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۴ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Poof 1 2009 1 ☐Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4, 300 Fa 1 Const. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hoove 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and many r as started.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) JODPIE D40324 NOVEMBER 12, 2009 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 7600 CARROLL AVENUE, TAROMA PARK, MARYLAND TERRY JODGE, MO, FACEP 31. Date filed (Month, 32. Registrar's Signature State NOV 1 6 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11. 2009 November 2:20 P. Susan Jane Baltimore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Hours 12/23/1929 Director Yrs Warrenton, Va. 577-38-8689 28a-f shov 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director D.C. Washington 1 Yes 2 No 10e. Street and Number 10f, Zip Code ò 10g. Citizen of What Country? Funeral 23a 20011 4840 New Hampshire Ave., N.W. # 1 U.S.A. items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ò \$ 1 X Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Custodial GSA/U.S.Government 8th should be filed we and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Maggie Baltimore permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic in pnee. Unknown traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaree Green/Daughter 434 Ross Road # 11, Greenbelt, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 11/20/09 Landover, Maryland 4 Donation 5 Other (Specify) Harmony Mem. Park 22. Name and Address of Facility
H. SWashington & Sons Co., Inc. 21. Signature of Funeral Service Licensee and 1 ale Burroughs Ave. N.E. Washington, D.C. 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition GIST Tumor Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year 1 Yes 2 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ျာ 1 🗌 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Il Director: And in by the f 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc determined 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Destriying hystication to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of

31. Date filed (Month. Da

NOV 1 A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sarah Bromelano, M.D.

1500 Forest

32. Regist

29c. License number

D62571

Glen Road, Silver Spring, Maryland 20910

29d. Date signed (Month, Day, Year) 11/12/09

State of Maryland / Department of Health and Mental Hygiena Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:12 A^M 11-07-2009 JUSTIN RANDOLPH BARBOUR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Fort Washington Hospital Fort Washington If Under 1 Year | If Under 24 Hrs. | Months Days Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □XM 2 □ F Yrs. **Director** 23 11-13-1985 DC 213-27-3141 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthan "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Prince George's Suitland Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20746 5212 Morris Avenue, Apt. 105 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1X Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 No δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 12th Cook nd 2 should be filed all the and Mental Hygic 27 is marked other! 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Blanche Saunders Bobby Barbour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5212 Morris Ave., Apt. 105, Suitland, MD 20746 Pages 1 and 2 ment of Health a Blanche Saunders/mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. 11-17-2009 injury or permit. Page Department of Importent: If any injury or once. Suitland, Maryland *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Tkolgman Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 MO1374 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nyroidism Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequend Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the use as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 □Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, á 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 12 No 1 □ Yes 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PR/Outpatient Medical Certification; To 3□ DOA within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D46741 November MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 LIVINGSTON RD. FORT WASHINGTON DEEPAK MD SACHDEVA 31. Date filed (Month, Day, Year, NOV 1 3 2009 State Registrar

Physician /Medical **Examiner**

Funeral Director

death with the Maryland 23a or 28a-f show traumatic event, the Medical Evanimer must be notified at or items permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Mydical Evan in augmen.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Box 68760. P.O. of Vital Records, Division

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3^{Day} Month Nov 2009 RICHARD BROOKS TIMOTHY 1615 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Prince Georges Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year) Days Country Hours 1 🖾 M 2 🗆 F Yrs. DĆ 579-64-0189 62 1, 1947 Nov. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Mitchellville MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10407 Forestgrove Lane 20721 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ∐Yes 2 🗷 No Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental Technician Self-Employed 2 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa M. Davis ဂ္ Drayton Shell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitchellville, Md. 20721 10407 Forestgrove Lane Bermuda Brooks-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-9-2009 Laurel, Md. 4 Donation 5 Other (Specify) Maryland National 22. Name and Address of Facility
Marshall's Funeral Homeof Maryland 21. Signature of Funeral Service Licensee Suitland Md. 20746 4308 Suitland Rd. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fatal Cardiac Arrythmia disease or condition resulting in death) Due to (or as a consequence of): Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No Asthma 24a. Was an autopsy performed 1 □Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 TxNo Certification: To 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) YIJU LIU 30. Name and address of pe who completed cause of death (Item 23a) (Type, Print) Yiju, MD 3001 Hospital Drive Cheverly, Md. 20785 Liu, 31. Date filed (Month, Day, Yea NOV 1 2 2009 State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	te of Maryla	•	artment of F rtificate of		Mental Hyg в	jiene _{leg. No} 2 (009	38186
			Decedent's Name (First, Middle, Last)					2. Date of Deat	th		3. Time of Death
	Physicia /Medic		Virginia Ann Carro					Novemb			5:30 A ^M
	Examin	er	4a. Facility Name (If not institution, give street a 9210 Crosby Road	nd number)		4b. City, Town, or Location of Death Silver Spring				nty of Death GOMELTY	,
and the second	Funeral		Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		_	lace (State or Foreign stry)
	Director		512-50-9986 1□ M 2	ΣF	62 Yrs.	Months Days	Hours Min.	Jan 26,	1947	Kansa	
	pu »		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	cation				1	0d, Inside City Limits
	Maryla f sho	lor							1 □ Yes 2 🛣 No		
	r 28a	irec	MD Montgomery 10e. Street and Number	51.	lver Sp	10f. Zip Code		1	0g. Citizen o	of What Coun	try?
	th with	ral D	9210 Crosby Road			20910		1	USA		
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evarrinar must be notified at once.	Funeral Director	1 Never Married 2 X Married 1 □	s Decedent Ever in ned Forces? Yes 2 X No	i	Was Decedent of H If Yes, specify Cuba		pecify Yes or No- o Rican, etc.)	В	lace - Americ lack, White, e	etc.
2-003p	hours a ural", o	d by	3 ☐ Widowed 4 ☐ Divorced Yea	es, Give ir or Dates:		1 ☐ Yes 2 📉 No	Specify:			^{cify:} Whit	
2	in 72 l	Completed	15. Decedent's Education (Specify only highest grade comp		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor.	king	16b. Kind of	Business/Ind	lustry
717	d with giene er tha	mo	Elementary/Secondary (0-12) Col	ege (1-4or 5+) 4	Tutor]	Educat	ion	
yland	be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, I	Maiden Surn	ame)	
<u> </u>	d Men narke natic	욘	Alfred Corsini		401 14 717			Oberzam	0.4	0	0.44
<u>a</u>	id 2 sh lth an 27 is n traur		19a. Informant's Name/Relationship (Type. Pri John G. Carroll/husba	•	1	ng Address <i>(Street</i> Crosby R			-		Code)
ē,	s 1 ar of Hea item 2		20a. Method of Disposition	20b		sition (Name of natory or other place			•	n - City or To	wn, State
E	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	from State		urney Cre		1/13/09 1	Woodbi	ne, MD)
baltimol	ermit. epartr nport: ny Inji	u	21. Signature of Funeral Service Licensee	//	Ĝ	2. Name and Addre	ss of Facility Cremation	on Servi	ce P.	O. Box	784
_	<u>o</u> □ ⊑ ∞ o		Bury LHeld	6 1	M01251B	everly L.	Heckrot	te, P.A.	Clark		MD 21029 Approximate
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1	Physician /Medical		disease or condition resulting in death)	ue to (or as a conse	equence of):	Cer					2-5 yrs
	Examiner		Sequentially list conditions b.								
-	red isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	ue to (or as a conse	equence of):						
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X O	attendi or use	lan/I	23b. Was decedent pregnant 23c. If y	es, outcome of preg	etal death 3	Ectopic pregnanc	ey .			Date of delive Month	ery Day Year
5	the de y the s ched f	Physician/M		Pregnant at time o Unknown	of death 5L	Other (specify) _					
7	s that gned b e deta	by Pr	Part II. Other significant conditions contributing	g to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?
cords	equire sen siç ould b			-				1 □ Y	es 217 No	3 ☐ Prob	oabły 4 🗆 Unknown
e E	has be	Completed						24a. Was a autops	sv I	prior to co	psy findings available mpletion of cause of
<u></u>	r: The ficate r, pag							perform 1 □ Yes	\sim	death? 1 ☐ Yes	2 □ No
VII	s certii	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	: 1 ☐ Inpatient 2	□ ER/Outpation	ot 3 🗆 DOA Oth		th (Check only or		Other (Specif	5.1
5	ig Phy ter this neral c	- 1	27. Magner of ath 28a	Date of Injury (Month, Day, Year)	28b. Time o			28d. Describe h			<i>y</i> /
2101	eath. or; Af the fur	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(monn, zay, rear)	,,		Yes 2 □No			_	
DIVISION	I or Att after d Direct I in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e	Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (S City or Town		mber or Rura	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burs after death. within 24 burs after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: O	To the best of my ken the basis of examind manner stated.	nowledge, deat ination and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time, o	cause(s) and date and place	manner as se, and due to	tated. the cause(s)
	To the within To the comple	Mec	29b. Signature and title of pertifier			29c. Licens			15	ned (Month,	
	7.5		> S. Wedan			VA O	101057	865	(1)	10/09)
	15		30. Name and address of person who complete	d cause of death (It	em 23a) (Type,	Print)	40 -		11	1) 20869
			Suparna Wedam:	32. Registrar's Sig	19c AV	e blogs	Kmbl	01,150	these	M, M	20009
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 0330M DWIGHT 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Davs Hours Min. (Month, Day, Year) 07/02/3 Country) Director 250-54-2217 76 South Carolina Usual Residence of Decedent show 10a. State 10b County ral", or items 23a or 28a-f shore Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No DC Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 5707 2nd Street NE 20011 United States death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Force ò 1 Never Married 2 X Married ☐ Yes 2 🔀 No Maryland 21215-0036 hours after Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 'natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sanitation Worker Government 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ၉ Irvin Ceaser Rosa Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5707 2nd Street NE Washington, DC 20011 Edith Ceaser/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/09 Landover, Maryland ature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc 4001 Benning Rd. NE Washington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a Vancomyun Resistant Enterococcus and disease or condition Medical resulting in death) premoniae bacteremia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Prostelle Cancer Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number Saluzasai Man, MD D0063703 11/09/09 TAKOMA PARK, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNR SABYASACH 31. Date filed (Month, Day, Year) NOV 1 6 2009 State arke Registrar

State of Maryland / Department of Health and Mental Hygiene 38188 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11 2009 11 9:48 A COLEMAN В. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES PRINCE GEORGES COMMUNITY HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 90 vrs Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 □ M 2 🕱 F Yrs 09 25 1919 Director SOUTH CAROLINA 579 24 4518 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at WASHINGTON DC 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20017 UNITED STATES 4729 - 12th STREET N.E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc filed within 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: BLACK ģ ¥☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED 12th HOUSEWIFE 2years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked oth any Injury or other traumatic evem Be BUCK WILLIAM ANNIE BELLE HEMINGWAY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 STATWOOD AVENUE OXON HILL, MARYLAND 20745 TERRI TAYLOR/ NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specific 11-18-2009 BRENTWWOD, MARYLAND LINCOLN 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME LLC 21. Signature of Funeral Service Lice Men 1 3005 12th STREET N.E. WASHINGTON, DC 20017 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) CARDIOPULMONARY ARREST /Medical Due to (or as a consequence of): Examiner CARCINOMA LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ SEVERE DEMENTIA, OSTEOPOROSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2 No certificate 1 ∐Yes 2 ∐No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1∐ Yes 2 ∏No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred

spital or Attendi lours after death. neral Director: / To the Hospital o within 24 hours aff

D45490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 DR. YUDHVIR GUPTA 31. Date filed (Month, Day, Year) -32. Registrar's Signature State Registra

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Natural

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

2 Accident

5 Pending investigation

6 Could not be

determined

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene ? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Novembe 10:454 M 200 Donald Charles Curran /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, **Funeral** Days Months Hours Min. 1 X M 2 □ F Yrs. 496-30-0136 76 Director May 26, Saint Louis, MO 1933 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examirer must be notified at 1 X Yes 2 No Director Maryland Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6641 Chestnut Avenue 20784 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: 1954–1957 1 ☐ Yes 2 🖾 No Specify: <u>ک</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Library of Congress The Associate Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental ant; If item 27 is marked o Thomas Curran Dorothy Hackman ೭ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra C. Curran / Wife 6641 Chestnut Avenue, New Carrollton, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery | 11/13/2009 | Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 51244 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No ned by the a 9 🗆 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ PROSTATE CANCER 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an page 2 s has autopsy rmed? 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 10/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 818 GOODUKK ARORA MDRYLAND 20706 LANHAM

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 2 2009

Maryland 2121

Baltimore,

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Quillia Mae Clark 2009 P^{M} 3:00 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Thomas More Nursing Home Hyattsville Prince George's | If Under 1 Year | If Under 24 Hrs. 8 Date of Birth | Months | Days | Hours | Min. 8 / 31 / 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 578-22-9787 97 Mississippi Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and the notified at DC Washington Director 1√Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20017 1220 Quincy St NE United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify ۾ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Binder Federal Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LT Watkins Laura (unknown) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anita C. Tennant (daughter 15th St NW Apt#209 Washington, DC 20005 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 11/14/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Euneral Service Licensee 3401 Bladensburg Rd Brentwood, MD 20722 Juhar non 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an arrest line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buris Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No : After this certification of the things of Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 29c. License number 2006 36 81 29b. Signature and title of certiffer 29d. Date signed (Month, Day, Year) 09

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ajit Kurup, MD 4922 LaSale Rd. Hyattsville, MD 20784

			For State At Registrar	mend ite.	State of Manager	dr.,	goad Cel	tificate of	Death			Reg. Nd	2009	38191
	Physicia	n/	1. Decedent's Name	(First, Middle, Las	et)					2	2. Date of Dea		y Year	3. Time of Death
T- 4.	Medic	al	4a. Facility Name (if n	WTLLTAN		CRC	MWELL	4b. City, Town, o	r Location		Novembe			
	Examin	er			al Hospit	٦٥		Frede		or Death		1	County of Dea Frederi	
	Funeral		Social Security Nur	mber 6. S	7. Ag	e (In yrs. la	st birthday)	If Under 1 Year Months Days		24 Hrs. 8	3. Date of Birt	h	9. Bi	rthplace (State or Foreign
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	and show dat	tor		10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
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	ems 2	Funeral	11. Marital Status	35 DLOOK	12. Was Decedent B	Ever in U.S	. 13.1	Was Decedent of H	lispanic Ori	gin? (Specif	fy Yes or No-		USA 14. Race - Ame	erican Indian.
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marrie 3 ☐ Widowed 4		Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No		f Yes, specify Cuba 1 ☐ Yes 2 🛛 No			can, etc.)		Black, Whit	
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mor	Page 1 nent of ant: If it Iry or o		1 ☐ Burial 2 🛭		Removal from State	CE	emetery, crer	natory or other pla					•	
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Fune			M0117	22	2. Name and Addre	ss of Facilit	y Keen	ey & Ba	asfo	ord P.A.	Maryland F.H.
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Phys /Me	ician idical	GRACE O. DAVII)			NOVEMB		3:05 P M	
Exan	niner	4a. Facility Name (If not institution, give street and number)		**	Location of Death	1	4c. County of Death		
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baltimo permit. Pages Department or Important: If i	ouce.	21. Signature of Funeral Service Licensee		. Name and Addres	J		nkins Funer		
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Physicia /Medica		shock, or heart faiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BURKITTS LET a. a. Due to (or as a consequence)		/LYMPHOMA	A			6mos	
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) June		D205	42		11-13-2009	9	
2 2		30. Name and address of person who completed cause of death (Item		·	OUT NOT	DC 000	10		
	State	JOSEPH CATLETT M.D. 110 IRVING 31. Date filed (Month, Day, Year) 32. Registrar's Sign at		T N.W. WA	ASHINGTON	,DC 200	10		
Regi		31. Date filed (Month, Day, Year) 32. Register's Signet	ace						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 Nov. PAUL DUNCAN 0150 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Prince Georges Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours GA GA 1K M 2 □ F Sept. 19 Yrs Director 578-66-4369 61 1948 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Expressional to a multiled at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 K Yes 2 □ No Director DC Washington 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 3725 Jay St. NE #7 20019 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc 1 ☐Yes 2 🔯 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 【XNo Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th **EXPEDX** Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pertifton Duncan Bertha Mae Owens ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jackson-Sister 301 Ridgely St. Upper Marlboro, MD. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 11-13-2009 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Md. 22. Name and Address of Facility Marshall's Funeral Home of Maryland 21. Signature of Funeral Service License 4308 Suitland Rd. _Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a Fatal Cardiac Arrthmia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Herniation of brain Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner anding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy performed 1 □ Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XINo 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

or Attending Physician: The law requires that the death certificate be executed **Division** Director:

Maryland

Saltimore,

Box 68760,

P.O. I

of Vital Records,

certificate

After

State

3001 Hospital Dr. Gaddipati Swapna 92. Registrar's Signat

G. Swapma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month,

NOV 1 3 2009

Registrar

D0069341.

Cheverly, Md. 20785

11/4/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lurlean Diggs November Day 2823 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Hospital Lanham P.G. 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth 1 🗆 M 2 🖵 F Days 059-20-2838 Months Hours Min. (Month, Day, Year) Director 93 S.C. 18-1916 Usual Residence of Decedent than "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location Director 10d. Inside City Limits D.C. Washington 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1741 D St. N.E. 20002 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married within 72 hours after 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any hiury or other traumatic event, th. Monge. Elementary/Seconday (0-12) College (1-4 or 5+) Private 8 Domestic Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Christopher Ella Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 James Christopher (Brother 1741 D St. N.E. Wash, D.C. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 11-14-09 Wash, D.C. Olivet Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral 908 Kennedy St. N.W. 20011 Hunt Wash, D.C. neures 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ep Ci disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CO. Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Bowe physician and the burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Dem en Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖾 No Pregnant at time of death 5 Other (specify) Month Day Vear ed by the a 9 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🏿 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mukemil Abdella, mo 11107108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn Dale, MD. 20769 Abdella, mo 1200 Annapolis

Registrar

State

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JAMES Α. DEAL Nov. 2009 6:15 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges St. Thomas More Hyattsville 8. Date of Birth (Month, Day, Ye Apr. 21, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) 1**⊠** M 2□ F 92 1917 577-09-2567 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examination multiple included 1 ☐Yes 2 No Director Hyattsville Prince Georges 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code 20782 USA Funeral 5821 Queens Chapel Dr. 12, Was Decedent Ever in U.S. Armed Forces? 1 X es 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc 1 XYes 2 If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 🖾 No Specify þ 3 Widowed 4 Divorced Black unknown Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk US Postal Service yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be 2 James G. Deal Cora Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is any injury or other trausonce. 9039 Sligo Creek Pkwy #216 Silver Spring, Md. 20901 Robert J. White - Cousin Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-13-2009 Harmony Memorial Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Marshall's Funeral Home of Maryland Icho 4308 Suitland Rd. Suitland, MD. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a ARTERIOSCUETATIC CARDIOVASCULAR DILEASE Immediate Cause (Final Physician ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Vear 5 Other (specify) the □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 DATE DIJECTION (NOT OPENated 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Anemia Pleural e Ffusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Chronic Kidney Disease this certificate 2 2 10 1 □Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) eensbyry Ed Hattsville M) 20181 MI) 4203 (EVORE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

NOV 1 2 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 38196 1 - State Registrar Amend#26. PerPhys. PGC11-12-09 Cartificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 0711 JENPURT ANNE Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince Geroge 4311 Lori Street Suitland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min 1 🗆 M 2 🗷 F (Month, Day, 09/11 Yrs 79 Pennsylvania Director 578-50-7891 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🔀 Yes 2 🗌 No Ft. Washington MD Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 303 Dias Drive 20744 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Government English Teacher $5\pm$ 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Elizabeth McCrae Rev. Stewart A. Davenport 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health a Fort Washington, Md. 20744 303 Dias Drive Carol A. Anderson/ Daughter or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1. Department of I Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland 11/12/09 Lincoln Memorial 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service licenses 4001 Benning Rd. NE Washington, DC 23a. Part 1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury attending physician and for use as the burlal-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ed by the a 9 Unknown Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed: Yes after death.

Director: After this certific d in by the funeral director, 26. Place of Death (Check only one) To Be 25. Was case referred to medical examiner? Cousin's Hospital Other: 4 Nursing Home 3 Thesidence 6 Other (Specify)Home 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af
To the Funeral Di
completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ortifie 38 completed cause of death (Item 23a) (Type, Print) Name and address of person D 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend I tem 3 per phys. 6898 12/1/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 Q 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOV.10, 2009 12:26 p_M BILLY N/M/N DOTSON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MD.HOSP.CENTER CLINTON P.G. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** KY Country) 1 ₹ M 2 □ F Months Days Hours. Min. 1 1-12-1936 406-50-6515 **Director** 72 Usual Residence of Decedent 10a. State 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location filed within 72 hours after death with the Maryland Director MD. CHARLES LA PLATA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9161 PREFERENCE DRIVE 20646 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No USMC
If Yes, Give 1953-5
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BUSINESS OWNER SELF EMPLOYED 8th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES SCOTT DOTSON MYRTLE DAUGHTERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARRIE DOTSON-SPOUSE 9161 PREFERENCE DR. LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GARDENS 11-17-09 WALDORF, MD. 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between · CORONARY ARTERY DISEASE Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner IABETES MELLITUS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): CARDIOMYOPATHY nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEEP VENOUS THROMBOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CITRONIC OBSTRUCTIVE PULMORY DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? CHOLDNIC KIDNEY DISEASE perform 1 ☐ Yes 2 ☐ No 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 X No ၉ 1 N Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work?
1 Yes 2 No 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number D 4 8 1 5 8 29b. Signature and title of certifier NOU (0,

DHMH 17 Rev 7/2009

Registrar

Siscoursion

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9628 MARLBORD PIKE UPPER MARLBORD MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 2:45 P M Nov. C. Ellison Eric /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly Birthplace (State or Foreign Country)
 SC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/20/1964 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours 1 ☑ M 2 ☐ F Days 249-29-4138 Director 45 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, Ite Madical Examinations to a colling an Director 1 X Yes 2 No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3342 Mt. Pleasant St NW #6 20010 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 72 hours after 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Dry Cleaners 12 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Ellison, Jr. Amy McNeil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau 3342 Mt Pleasant St NW #6 Washington, DC Amy M. Ellison/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sandy Grove Cemetery: 11/14/2009 Bennettsville, SC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 Ninth Street, NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brain Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-trar Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □Yes No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2□No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral of Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 12 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier tix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Undedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title D55020

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Matin Mo

Baltimore, Maryland 21215-0036

Box 68760,

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of Vital Records,

Division

3001 Hosp Dr. Cheverly MD 20785

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tem 1 per dr., g899, 01/13/10dhbg899 Amend Items State of Maryland Department of Fleath And Mental Hygiene Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) Davis 2. Date of Death Campbel1 Elliott No Vember Year 2009 555 a M **Physician** CLLIOT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney-Keedy Nursing Home Boonsboro Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 🕅 M 2 🗆 F Director 86 April 21 1923 United Kingdom 218-02-9585 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 607 Sunset Avenue Funeral United Kingdom 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔯 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Financial Analyst International development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George Elliott Bertha Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health s permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr Gillian S. Elliott - Wife 607 Sunset Avenue, Hagerstown, Md. 21740 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory: 11/16/09 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses Calent B. Canke 415 E. Wilson Blvd. Hægerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re piratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardie uspirating disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MEDICAL EXAMINER Examiner burial-transit .81 Due to (or as a consequence of): CERTIFICA attending physician for use as the burial COR Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Left Hip Fracture 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed?

1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2 No Certification: To Hospital or Attending Pl 24 hours after death. Funeral Director; After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Subject tripped and fell backwards 5 Pending Injury 2 Accident 06/25/2009 1 ☐ Yes 2X No investigation Unknown^M filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10323 01d George— 4 Homicide town Rd.,Bethesda, MD Parking Lot 24 hours 29a. Certifier 1🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Muhammad Aph MI) 11-16-9 D0063502 30. Name and a dess of person who completed cause of death (Item 23a) (Type, Print) Haserstown, MD 21740 5H.4 32. Registrar's Signature 31. Date filed (Mon State Registrar Server S. park

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 [38200 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day Nielsen Physician /Medical Fairman -1.25 AM leen 08 2009 Nevember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year)
Feb. 22 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 195-50-6946 48 Yrs 1961 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d Inside City Limits 10a State 10h County 10c. City. Town or Location 28a-f show must be notified at 1X Yes 2 □ No Funeral Director MD Prince George's Bowie 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö items 23a 2811 Farris Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 Yes 2 No Specify \$ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Catscan Technician Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Fairman Miyoko Tanaka ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any Injury or other train once. Miyoko Fairman/ mother 20715 2811 Farris Ln., Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/2009 Bavview Crematory Baltimore, MD 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Patr 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C se (Final disease or condition resulting in death) **Physician** a metastatic breast /Medical **Examiner** Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mg Dav Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown þ Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 1 Tyes 2 **N**0 certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ this funeral (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Tes 2 [No death. 2 Accident Director; A 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rurel Route Number, determined 4 🗌 Homicide City or Town, State) To the Hospital c within 24 hours at To the Funeral D completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 08,2009 November DH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2000

		•	For State Registrar		State of Ma	aryland				Death		Re	g. No.	200		
	Physicia	an		_{le (First, Middle, Las} Fernandez	t)						l N	ate of Death	Dav	0, 2009	3. Time of 1:47	
	/Medic Examin				street and number)			4b. City, Town, or Location of Death					4c. County of Death			F
	Examili	e i	Casey Ho	ouse				Rockville					Montgomery			
	Funeral	-1	5. Social Security N	Number 6. Se		e (In yrs. la	ast birthday)	Monthe Dave Houre Min (Month, Dav. Year) Country					itry)	_		
	Director		114-38-1	461	Ž M 2□ F	60	Yrs.				Oct	27,	194	9 Puert	o Ricc)
	and		Usual Residence of 10a. State	f Decedent 10b. County		10c. City	, Town or Lo	cation				_		1	0d. Inside Cit	y Limits
	Maryi f sho	ō	MD	Montgome	27 37	Silv	er Spi	rina							1 ☐ Yes	2 X No
	the tree 28a	Director	10e. Street and Nu		ı. y	DIIV	er pp		ip Code			10	g. Citiz	zen of What Cour	try?	
	filed within 72 hours after death with the Maryland Hygene. other than "natural", or Items 23a or 28a-f show ent, the Medical Exa char must be notified at	<u>=</u>	8 Habers	sham Court	-	20906						บ	SA			
	death	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S	5. 13.	Was Dec	edent of H	lispanic Origin? an, Mexican, Pue	(Specify \	Yes or No- n, etc.)	1	4. Race - Americ Black, White,	an Indian,	
0	or ite	y Fu		ried 2 Married	1 XYes 2 □ N				2□No	Specify: Pu				Specify: Blac		
0000	hours tural"	ed by	3 Widowed		Year or Dates:	1968-	16a. Dece	dent's Lis	ual Occur		erto			BLAC nd of Business/In		
Ċ	in 72 "nation" r	Completed		15. Decedent's Ed			(Give	kind of w	ork done o use retired	during most of w d)	orking		OD. TUIT	14 07 04011000111	2001.)	
7 7	r than	mo.	Elementary/Sec	ondary (0-12)	College (1-4or 5)+)	Perfo	rming	y Art	ist			Ente	ertainme	nt	
5	e filed al Hyg l othe vent,	Be C		(First, Middle, Last)						18. Mother's N						
y	Ment Arkec arkec	인	Ramon Fe							Angela						
<u>a</u>	2 sho h and is m raum			lame/Relationship (_{Type.Print)} -Tearte/si:	ctor				and Number or . k Lane				Town, State, Zip	Code)	
e,	1 and Health em 27 ther t		20a. Method of Dis		-rear ce/sr						Date			cation - City or To	wn, State	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghen. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is located by clinic must be notified at once.		1 ☐ Burial 2		Removal from State		lace of Dispo emetery, crei				11/13			bine, MI		
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ľ			23a. Part1. Enter	the disease, or compart ailure. List only	plications that caused one cause on each li	the death	n. Do not en	ter the m	ode of dyir	ng, such as card	iac or res	spiratory arre	est,		Approximate Interval Bet	e ween
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	/Medical Examiner		resulting in death		Due to (or as	a consequ	uence of):									
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۵ 2	ath ce	lan/	23b. Was deceded		23c. If yes, outcome	2 Feta	death 3		pregnanc	су			2	23d. Date of delive Month	,	Year
5	the a	Physician/M	1 □Yes 2 9 □ Unknow	□No	4 ☐ Pregnant a 9 ☐ Unknown	it time of d	eath 5	Other (specify) _							
7.	Physician: The law requires that the death certific this certificate has been signed by the attending train director, page 2 should be detached for use as				ontributing to death b	ut not resu	ulting in the u	underlying	cause giv	en in Part I.		23e. Did tob	acco u	se contribute to t	he cause of c	leath?
SD	uires n sign fd be	d by	Chronic	renal dis	sease						_	1 □ Ye	s 2[□ No 3 □ Pro	bably 4 🗆 l	Jnknown
ecords	law reclass been 2 shou	Completed									-	24a. Was ar		24b. Were aut	psy findings	available
ב	The la ate ha	uo.			***							autops perform 1 🗆 Yes 2	y ned?	death?	ompletion of o	ause of
VITAI	ian: rtifica tor, p	Be C	25. Was case refe	erred to medical						26. Place of E				10100	2	
	Physician: r this certific ral director,	70 E	examiner? 1 ☐ Yes 2 2	∑ No	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatie	ent 3 🔲	DOA Oth	ner: 4 🗆 Nursing	g Home	5 Reside	ence 6	6 Other (Spec	_{fy)} hosp	ice
n 01	ding Physician: h. After this certific funeral director,	on:	27. Manner of Dea	ath 5 Pending	28a. Date of Inju (Month, Da	ıry a <i>y, Year)</i>	28b. Time of Injury		28c. Inju Wor		28d.	Describe ho	w injury	y occurred		
<u> </u>	tendi leath. tor: A	cati	2 Accident	investigation 6 ☐ Could not be				M		lYes 2□No	204	Location (C4		d Number or Rui	ni Bouto Num	abor
UIVISION	al or Attending P after death. I Director: After d in by the funera	Certification:	4 ☐ Homicide	determined	e 28e. Place of In building, e	c. (Specif	y)	reet, lact	ory, ornice		201. 1	City or Town	, State)	ai i ioute ivan	1061,
_	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier	1X CertifyIng Ph	nysician: To the best	of my kno	wledge, dea	th occurre	ed at the t	ime, date and pl	ace, and	due to the c	ause(s)) and manner as	stated.	
	n 24 }	Medical	(Check only one)	2 Medical Exar	miner: On the basis of and manner st		ition and/or i	nvestigati	on, in my	opinion, death o	ccurred a	at the time, da	ate and	place, and due	to the cause(s	S)
29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (M. November: 1																
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		to	31. Date filed (Mo	onth, Day, Year)	ou, M.D. 6	rar's Signa	ture			Ka. Koci	KV11	re, MD	20	022		
	Sta	(Le		MOV 13 2	nno /		1 1	Ma Na	1							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 11/06/09 **Physician** 1155 Melva Frost /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 212-74-2274 56 09/16/53 DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1x Yes 2 □ No Director Maryland | Montgomery Montgomery Village 10g. Citizen of What Country? 10e. Street and Number 9711 Lake Shore Drive 20866 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Folder Operator is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental Melvin McCooke Frost Delores Delrio Briscoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:8 Department of Health a Important: If item 27 is any injury or other trau once. Frederick, Md. 21703 212 Appleton PLace # 1-C Melvina Frost/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Landover, Maryland 11/16/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Rd. Washington, DC 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of) Examiner Anemia Sequentially list conditions, if any, leading to immediate occor. Enter the certific Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed g physician and ss the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending physical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a 1 ☐Yes 2 TNo 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð Deep Venous Trombosis 1 ▼ Yes 2 No 3 Probably 4 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 🖾 No page 2 certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No t ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Janell Williams MD

9901 Medical Center Rockville, MD

20850

		•	For State Registrar	State of Ma	ai yiailu i	•	tificate of			Reg. No. 2	009	38203
	Physicia	an	1. Decedent's Name (First, Middle,						2. Date of De Month	ath Day 9	2009	3. Time of Death
	/Medic		WILLISTINE	FOUNTAIN					Nov.			7:15 a ^M
	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, or Forestv		tn	4c. County of Death Prince Georges		
AP.			Forestville Reh		le (In yrs. last		If Under 1 Year	If Under 24 Hrs	8. Date of Bir		lace (State or Foreign try)	
	Funeral Director		5. Social Security Number 125-24-4309 Output 6. Sex									
	/land		10a. State 10b. County		10c. City, T	own or Lo	cation				1	0d. Inside City Limits
	Many a-f sh	tor	MD Prince	Georges	Suit	1and						1 ☐ Yes 21X No
	or 28)ire	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	try?
	th wit	ral	6020 Goodfello	w Dr.			20746			USA	<i>A</i>	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Evenines must be redified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Armed Forces? 1 □ Yes 2 🔀			Was Decedent of H f Yes, specify Cuba		Specify Yes or No rto Rican, etc.))- 14. I	Race - Americ Black, White, 6	
036	ursaf al", or	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I∐Yes 2⊠No	Specify:		Spe	ecify: Bla	ick
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21215-0036	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5			kind of work done of NOT use retired		9	Don't are		
	lled w lygie ther th	ပိ	10th 17. Father's Name (First, Middle, L	actl		неатт	:h Care W		me (First, Middle	Priva		<u> </u>
Maryland	d be fi	Be	Lawrence Jacks					Jannie		,	,	
Z	should bd Me mark matic	ည	19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street			er, City or To	wn, State, Zip	Code)
	nd 2 salth ar 27 ls 27 ls r trau		Robert A. Foun				Goodfell		Suitland			
re,	s 1 al of Hee item othe	li	20a. Method of Disposition		20b. Plac		sition (Name of natory or other place		Date		on - City or To	wn, State
E	Page nent c int: If		1 ☐ Burial 2 🗷 Cremation : 4 ☐ Donation 5 ☐ Other (Sp		1		itan Crem	i	-16-200	9 Alex	xandria	a. Va.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Experiment must be rediffed at once.		21. Signature of Funeral Service L	icensee	Mo	Mã	Name and Addre	ss of Facility Funeral	Home of	Mary1	land	
			23a Part 1 Enter the disease or o	complications that caused	d the death.		308 Suit1		Suitlar ac or respiratory a		20746	Approximate
E	Dhusisian		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final		ne.		,	<i>J</i> ,				Interval Between Onset and Death
	Physician //		disease or condition resulting in death)	a. Stroke Due to (or as	a consequer	nce off.						
1	Examiner			Hyperte		100 01).						
	7 +	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as		ice of):						
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68760,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequer	nce of):						
387	tificate ig phys as the	ledical		d								
Box (IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7			23d.	. Date of delive	ery
œ.	that the death ce	Physician/N	in the past 12 months? 1 □Yes 2 ☑No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			☐ Ectopic pregnand ☐ Other (specify) _	;y			Month	Day Year
P.O.	at the d by the	Phy	9 Unknown			!- .		on in Dont I	22a Did	tobacco use	contribute to t	he cause of death?
Division of Vital Records,	The law requires that the de ate has been signed by the page 2 should be detached	Completed by	Part II. Other significant condition Cancer of Head		out not resultii	ng in the u	nderlying cause giv	en in Fart i.	- 17			pably 🔼 Unknown
eco	law re as be	plet							24a. Was	psy		psy findings available mpletion of cause of
= =	The ate	Con								ormed? 2⊠No	death? 1 □ Yes	2 🖾 No
/ita	ician; Thi certificate ector, pag	Be	25. Was case referred to medical examiner?	bloopital			Oth		eath (Check only	one)		
of \	Physician: r this certific ral director, I	은	1 ☐ Yes 2 🖾 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inji	ient 2 EF	NOutpatie		4 🖭 Nursing	Home 5 ☐ Res 28d. Describe			fy)
uo	ding h. After funer	io	1 X Natural 5 ☐ Pending	(Month, Da	ay, Year)	Injury	Wor	k? Yes 2 □ No	20d. Describe	now injury oc	Sourca	
Visi	Attending er death. rector: Afte by the fune	Certification: To	2 Accident Investigation 3 Suicide 6 Could not determine	ot be 28e. Place of Ini	jury - At home tc. (Specify)	e, farm, str	eet, factory, office		28f. Location	(Street and N	lumber or Run	al Route Number,
	tal or rs afte al Dir led in	Cer							1			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		Physician: To the best Examiner: On the basis of and manner st	of examinatio							
	To the within 2 To the complete	Me	29b. Signatura and title of certifier				29c. Licens				igned (Month,	
) // // ()				D 5	1520		11-	10-2	009
	2 2		30. Name and andress of person v	who completed cause of	death (Item 2	3a) (Type,	Print)					
7	U 5		Dr. Bahram Pish				ve. SE S	Suite 310) Washi	ngton,	DC 20	0032
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 2 2009		rar's Signatur		•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 20 2009 ar **Physician** MARGARET REED FOWLER 3:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA 8. Date of Birth (Month, Day, Feb 10, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 2 💆 F Months Days Hours Min. North Carolina 59 1950 579-68-5801 Director Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location ed other than "natural", or Items 23a or 28a-f show event, the Medical Examination could be notified at 1 XYes 2 No Director Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1917 Rochell Avenue #1826 20747 USA Funeral death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 ∐Yes 2X No Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2€No Specify Black 2 3 Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Reed Cooper Pauline Ebo 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1917 Rochell Avenue #1826, District Heights, MD <u> Katrina Cooper (Daughter)</u> permit. Pages 1 a
Department of Hee
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/1/2009 Hanover, MD Ardent Crematory 22. Name and Address of Facility Latimore Funeral Services, P.A. 21. Signature of Funeral Service Licer see alimor 9013 Annapolis Road, Lanham MD 20706 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Anoxic pusio in disease or condition resulting in death) 2 days /Medical Due to (or as a consequence of) Examiner Pneumonia 4 days Sequentially list conditions, any least conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of Examine certificate be executed Bronchiectasis and Due to (or as a consequence of) signed by the attending physician a I be detached for use as the burial-Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? certificate 2 **V** No 2 □ No 1 🗆 Yes 1 Yes Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ ð this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident i or Attend after death Director: filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Pospital of 24 hours a Funeral D 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00069249 November, 20, 2009

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Sign

RACHEL GREENBERG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

D

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CENTER DRIVE, BETHESDA, MD 20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Joseph D. Giordano 2009 j) M November 3:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Health Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 22 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days 1 M 2 D F Hours Min. 577-38-6323 90 Director 1919 Pennsylvania Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the M dic I Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 Yes 2 YNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral 2656 Compass Drive 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married 1 No 1f Yes, Give Year or Dates. 1936–67 Maryland 21215-0036 1 Yes 2XXNo Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sergeant Major 11 U.S. Army Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sam Giordano Dominica Napolitano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Giordano/wife 2656 Compass Drive Annapolis, Maryland 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 11/11/2009 | Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complete attents that cause shock, or heart failure. List only one cause on each line, ediate Cause (Final ase or condition Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner N Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò ischemic cardiom yopathy
malignant ventricular arrythmias To the Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irector, page 2 s autopsy perform 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural n 24 hours after death.

e Funeral Director: Afte bleted filled in by the fun 5 Pending Accident 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one)

State

29b. Signature ar

30. Name and address of person

Box 68760

P.O.

Registrar DHMH 17 Rev 7/2009 NOL

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

m021114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ SOPHIA J GOODMAN NOVEMBER 10 2009 11:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death **HEARTLAND HOUSE** QUEEN ANNE'S GRASONVILLE 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days JANUARY 4, 1916 196-03-5928 93 DELAWARE Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director **MARYLAND OUEEN ANNE'S** QUEENSTOWN 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 WYE ACRES ROAD 21658 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black. White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates "natural", Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CASHIER RETAIL Be other traumatic event, 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental F tem 27 is marked o ည STANLEY ORLOWSKI ANTONINA BUDSIZUSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 109 WYE ACRES ROAD, QUEENSTOWN, MD 21658 SHIRLEY HENRY/STEP-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State NOV Date 14 cemetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State ZION CEMETERY 2009 HIGHLAND, MD 4 Donation 5 Other (Specify) 21. Signature of uneral Service Licensee FELLOWS Addreffenbein & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 te disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Ente Approximate shock, or heart failure. List only one Interval Between Immediate Cause (Final Onset and Death Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral inverted inverse of the purial-transit (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 ☐ Yes 2 🛣 No Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 127055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL H. WILKERSON, M.D. 205 MEDICAL CENTER ROAD, GRASONVILLE, MD 21638

Registrar

31. Date filed (Month, Day, Year)

NOV 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38207 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DORYCE GLUBUS 0931 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 930 Astern Way, Unit 605 Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. 12/20/1923 North Carolina Director 579-20-9583 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Marvland 1 🗌 Yes 2 🎇 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 930 Astern Way, Unit 605 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Bracey Iva McGirt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3539 South River Terrace, Edgewater, MD 21037 <u>Karla Dee Diaz</u>/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 11/10/09 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland 21. Signapore of Judey Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final MENTA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending housing and the attending physician and hed for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 9 Unknown rate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending 2 🗌 No 1 🗌 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in ring opinion, useful occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of EFENSEHIGHWAY ANNAPOLI, MOZIYU) ame and address of per (CHARA 31. Date filed (Month, Day, Year) Registrar

		For State Registrar	State	of Marylan	-	artment of H tificate of D		Mental Hy	giene Reg. No.2 (09	38208
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Exam		4a. Facility Name (if not institution			-	4b. City, Town, or	Location of Deat	4c. Coun	ty of Death	1.0	
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Ifften 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Fo	2 🖾 No ve	l I	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ace - America ack, White, e fy: whi	tc.
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Baltimore, permit. Page 1 and Department of Hea Important: If them any injury or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 Bemoval from			sition (Name of natory or other place	e) Nov	Date ember	20c. Location	- City or To	wn, State
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Depart		21. Signature of Funeral Service	Ronkin	-		Name and Addres					yland 21740
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Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certifics as after death. It Director. After this certificate has been signed by the attending pet in by the funeral director, page 2 should be detached for use as it.	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	gnant at time of c	Ideath 3	Ectopic pregnanc Other (specify)	у		5	ate of delive Month	ry Day Year
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SHS		30. Name and address of person		se of death (Item	23a) (Type, P	rint)		21740			
	ate rar	31. Date filed (Month, Day, Year)		gistrar's Signat	ture	agerstow	• '				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/05/09 Physician/ Joseph E. Grady Jr. 3:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Rehabilitation Center Waldorf Charles County Social Security Number 6. Sex 1 ♣ M 2 ☐ F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. Hours (Month, Day, 03/11 Country) Director 71 579-50-6056 Usual Residence of Decedent show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Charles County Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5924 Michael Road 20601 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 X Never Married 2 Married ģ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Masonary Worker Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph E. Grady, Sr. Charlsie M. King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly A. Davis/ Sister 5924 Michael Road Waldorf, Maryland 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 11/11/09 Waldorf, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physiciani <u> Arteriosclerotic Cardiovascular Disease</u> disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate tompleted filled in by the funeral director, page 1 ☐ Yes 2 🔀 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

CR 5

State Registrar Philip Wisotsky, M.D., F.A.C.P. 12070 Old Line Centre, # 207 Waldorf Md. 20602
31. Date filed (Month, Day, Year)
NOV 1 6 2009

ss of person who completed cause of death (Item 23a) (Type, Print)

D18545

11/11/09

			For State Registrar	State of Mar		artment of rtificate of		and M		giene Reg. No	71110	38210
			1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		MARILYN ROSSLYN	GRIGGS					Month — C)4-2	009 Year	4:20 PM
,	Examin		4a. Facility Name (If not institution, give			4b. City, Town,		of Death		- 1	. County of Deat	
			Prince George's			Chever		24 Ura	0 D 1 (D)		rince Ge	
	Funeral Director		5. Social Security Number 6. S		In yrs. last birthday) 77 Yrs.	Months Day		Min.	8. Date of Birt (Month, Da 04-30-	tn i <i>y, Year)</i> -103	9. Birt Co	hplace (State or Foreign untry) VA
			227-38-8253 Usual Residence of Decedent		1 1				04 30	175	4	V11
	how	_	10a. State 10b. County	1	0c. City, Town or Lo	ocation						10d. Inside City Limits
	e Mar 3a-f s	Director	Maryland Prince G	George's	Capitol	Heights						1 X Yes 2 □ No
	ith th	Dire	10e. Street and Number			10f. Zip Code					tizen of What Co	untry?
	s 23a	eral	408 St. Margaret's			20743			7. 17. 11		SA	
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ XNo	er in U.S. 13.	Was Decedent of If Yes, specify Cu	r Hispanic Ori iban, Mexicar	n, Puerto	Rican, etc.))-	14. Race - Ame Black, White	e, etc.
920	al", or	by	3 ☐ Widowed 4 ☒ Divorced	if Yes, Give Year or Dates:		1 □Yes 2 🗓 N	o Specify:				Specify: B1a	ıck
21215-0036	72 ho	Completed	15. Decedent's Ed	ucation		dent's Usual Occ		t of worki	na	16b. F	(ind of Business/	Industry
2	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	/ife.	DO NOT use reti	red)	or Work	ng .	ъ.	6.0	1 0 1
2	should be filed within 72 hours after death with the Maryland of Mental Hyglene. merked other than "natural", or items 23a or 28a-f show matte event, the fredical Exactive rate by confined and the fredical Exactive rate by confined at the fredical Exactive rate by confined at the fredical Exactive rate by confined at the fredical Exactive rate by confined at the fredical Exactive rate of the f		12th 17. Father's Name (First, Middle, Last)		Bus	Attendan	T	ar's Name	(First, Middle,			ol. Gov't
au	be d d	Be c							Washing			
Maryland	2 should be fi and Mental I is merked of aumatic ever	으	Unknown 19a. Informant's Name/Relationship (7)	Type. Print)	19b. Maili	ng Address (Stre				_		Zip Code)
	d tra		Carolyn Briggs/dau	ighter	408 S	t. Marga	ret's	Dr.,	Capito1	l He	ights, N	1D 20743
Jre,	of He		20a. Method of Disposition		20b. Place of Disponentery, cre	osition (Name of matory or other p	lace)		Date	20c. L	ocation - City or	Town, State
altimore,	Page ment ant: I		1 🕅 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Specif</i>)	/)	Natl. Har			11-1	2-2009	Lan	dover, N	Maryland
Balt	permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other once.		21. Signature of Funeral Service Licen			2. Name and Add		,	DA A	C		MD 207/6
	<u>20</u> = 00				. /						ultland	, MD 20746
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	le death. Do not en	ter the mode of d	1	4	-	irresi,		Approximate Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)	a. Tata Due to (or as a d	CONVOL	-1ac	HYY	974	mia	_		
-	Examiner			Due to (or as a t	onsequence or,		(J				
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	consequence of):							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician end bage 2 should be detached for use as the burial-transit		resolving in dealty cast	Due to (or as a o	consequence of):							
687	physicate physicate	dicai	•	d								
Box (eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date of de	livery
W	death	icia	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		☐ Ectopic pregna☐ Other (specify)					Month	Day Year
P.O.	et the de	Physician/Me	9 Unknown									
S,	res the signed be def	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	underlying cause	given in Part I	l.	-	tobacco Yes 2		the cause of death?
of Vital Records,	w requir s been s should	Completed										
Rec	: The law cate has I page 2 s	ldm							24a. Was auto perfo		prior to death?	utopsy findings available completion of cause of
ta			25. Was case referred to medical				26 Plane	o of Doot	1 ☐ Yes	2 N		3 2 □ No
>	S 0 75	To Be	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatient	2X ER/Outpatie	ent 3 DOA	Whor:		h <i>(Check only o</i> me 5 □ Resi		6 ☐ Other (Spe	scifu)
סר	ding Phys h. After this funeral di	T:U	27. Manner of Death	28a. Date of Injury (Month, Day,	28b. Time of		jury at /ork?		28d. Describe			J. I.
<u>Si</u>	Attending ir death. ector: After by the funer	catic	2 ☐ Accident investigation			M 1	□Yes 2□]No				
Division	⊒ affe ⊆	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, st (Specify)	reet, factory, offic	e		28f. Location (City or To			ural Route Number,
	To the Hospital within 24 hours and the Funeral I completely filled	edical C		ysician: To the best of niner: On the basis of e								
	To the Hos within 24 ho To the Fun completely	Medi	one) 29b. Signature and title of certifier	and manner state		-	ense number				ate signed (Moni	
	ĕ≱≓ŏ		54,001	A1.10.			+063	2 T M	n0	11	16/09	,
	5		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	1	7000) /		- 11	10101	
<u> 1</u> '			Ethropia Abebe,	1221 Me	rcantile	Lane, La	argo, N	MD 20	774			
	Sta	ita	31. Date filed (Month Oax Year)	32. Redistrar	A Replan							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary A. Gesko November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral Days 1 🗆 M 2 🕱 F Months Hours Brownsville, PA 190-16-3620 Director 86 January Usual Residence of Decedent show per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland De; artment of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's College Park 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5022 Geronimo Street 20740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 X No þ 1 Yes a Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Dorsey Jacob Kriss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5022 Geronimo Street, College Park, MD 20740 Sandra Bruckner / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greene County
Memorial Park Cemetery 20a Method of Disposition 20c. Location - City or Town, State 1 🛛 Burial 2 🗌 Cremation 3 🔲 Removal from State Waynesburg, Pennsylvania 11/14/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 TRAY ROBERS Gasch's Funeral Home, P.A. . Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) 9 DAYS erensovas Medical Due to (or as a consequence of) Examiner Sequentially list conditions, deny leading to influence cause. Enter Underlying Cause (Disease or iinjury Due to for este nonsequence offi-Exam and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 No Hospital or Attending Physician: 24 hours after death. completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 K No ဂ 1

■ Inpatient 2

ER/Outpatient 3

DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide work? 1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

24 hours To the within 2

State Registrar

CAN 31. Date filed (Month, Day, Year) NOV 1 2 2009

Medical

29a. Certifier (Check

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DUJGGO

29d. Date signed (Month. Dav. Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38212 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 2009 8:11 PM DAMARIS GASPAR GASPAR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 32 Yrs. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea 9/20/1977 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F none Mexico Director Usual Residence of Decedent end 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits ral", or items 23a or 28a-f shore Mexico Virgencitas Nezahualcoyotl 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 57300 Mexico Virgen de la dolorosa #130 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: Mexican Specify Mexicana ģ 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12th grade Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amadeo Gaspar Gaspar Ricarda Gaspar Gaspar မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nezahualcoyotl 19a. Informant's Name/Relationship (Type. Print) Virgen de la dolorosa#130 Col. Virgencitas Mexico

Date | 20c. Location - City or Town, State item 27 i Josafat Acuna Rios (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other placements) of diego 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/17/2009 Sultepec, Mexico 4 ☐ Donation 5 ☐ Other (Specify) sanches 22 Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4217 9th Street, N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Septic Shoc Physician 2 weeks disease or condition resulting in death) /Medical Due to (o) as a consequence of) Examiner month DREUMONIO C Sequentially list conditions, the state of t Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed retractoru attending physician and for use es the burial-trar Due to (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform certificate 2 No 1 ☐ Yes 2 🖾 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No this c 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD038119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 BERNARD KIM 31. Date filed (Month, Day, Year) NOV 1 2 2009 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 23a per dr., g898,12/1/09dhb Reg. No. 1 - For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death tober Day SORDON Physician IRAC 18:06 M Barker Ann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 9, 1968 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex . Age (In vrs. last birthday) **Funeral** 1 M 2XX West Virginia 236-21-6990 41 Yrs. Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f shov 1 ☐ Yes XXNo Director **TATA** Great Cacapon Morgan ?7 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? with 1 10415 Cacapon Road 25422 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes XXNo Specify ģ Specify: 3 Widowed 4 Vivorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Gov't. IRS Computer Specialist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othin any linjury or other traumatic event, once. Be Harold Zane Barker, Sr. Patricia Llewellyn Holliday 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita J. Gleason - Sister 15225 Sovereign Place, Chantilly, VA 20151 20a. Method of Disposition
1 □ Burial XX Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Hagerstown Crematory 10/28/2009 Hagerstown, MD ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. M00522 95 Union St., Berkeley Springs, WV 25411-1855 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hyperammoremia

Due to hir as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and d for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 | No 1 Tyes 2 No this certificate spital or Attending Physician: Thours after death.

neral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES-000

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DHMH 17 Rev 1/2001

State Registr<u>ar</u> ANDREW

31. Date filed (Month, Day, Year)

T.

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32: Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0610 AM EVelyn NOV 9 200 /Medical 4o. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dorchester Kogo ambridge If Under 1 Year | If Under 24 H/s.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex **Funeral** 1 □ M 2 🖫 F Months Days 218-48-799 Usual Residence of Decedent 62 Feb. Director Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director orchest 10g. Citizen of What Country? 10e. Street and Number ŏ 2161 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗹 No Completed by 3 ₩Widowed 4 □ Divorced Black "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) H05p: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be llette EVELYN ၉ awrence Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is Cambridge MD,21613 333homas reek 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cambridge, MD. 16/09 4 ☐ Donation 5 ☐ Other (Specify) 11 21. Signature of Funeral Service Licensee 22. Name and Address Facility Henry Funeral Homisions Stowashington St. MD.21613 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** UCAL Co /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ Wo Month Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknown been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 XX0 1 🗌 Yes 3 Probably 4 Unknown Dectension page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy or Attending Physiclan: The certificate 2 XX0 1 ☐ Yes Division of Vital 1 ☐ Yes 2 ☑ No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 √9o Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Autural

2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury within 24 hours after death. To the Funeral Director: A 1 ☐Yes 2 ☐No the 3 🗋 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🔲 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) NOV 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NaRR

En

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32. Registrar's Signature

D.0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 M 2 X F Washington, DC 63 Sept. 225-66-2614 1946 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland|Queen Anne Grasonville Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21638 USA 253 Prospect Bay Drive West Funeral Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monce. Media Specialist Anne Arundel Co. School 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Folev Patricia Lawrence ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dee Humphrey/Husband 253 Prospect Bay Drive West, Grasonville, MD.21638 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Kalas Crematory 1 □ Burial 2 🏋 Cremation 3 □ Removal from State 11/11/2009 Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George F. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** etastake disease or condition cholongiocarcinoma resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, Examiner Physician/Medical þ Completed Be ၉ Medical Certification:

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the f

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

items 23a or

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"natural"

is marked other than

Examiner must be notified at

ause. Enter Underlying Jause (Disease or injury hat initiated events esulting in death) Last	c	, 		
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	ontributing to death but not resulting in	the underlying cause given in Part I.		se contribute to the cause of death?
Hepatic encephalopall Respondory failure	J		24a. Was an autopsy performed? 1 ☐ Yes 2 📉 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
5. Was case referred to medical		26. Place of Dear	h (Check only one)	
examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursing He	ome 5 Residence 6	B ☐ Other (Specify)
7. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	ime of 28c. Injury at Work? M 1 \(\text{Yes} \) 2 \(\text{No} \)	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, far building, etc. (Specify)	n, street, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
		death occurred at the time, date and place /or investigation, in my opinion, death occu		
9b. Signature and title of certifier		. 29c. License number	29d Date	e signed (Month, Day, Year)

RES-000

November 10, 2009

600 North Wolfe St, Baltimore, MD, 21287

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Crost Thomas

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** James F. Hudson 1140 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** at Tospice Wicomico Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F 89 Months Hours Min. 7/17/1920 (17) 216-14-2668 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Item Medical Evantment in cust be notified as 10d. Inside City Limits Director 1 ☐ Yes 2√ No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Carriage Lane 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify ģ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Instrumentation EI Dupont 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Franklin Hudson, Sr. Mary Ella Cathell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Carriage Lane, Berlin, MD 21811 Margaret Hudson / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Cape Henlopen Crem. | 11/13/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MALIGNANT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🗖 No 3 Probably 4 Unknown should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one, Hospital: Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) 5 Residence HOSP (CR 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

The law requires that the death certificate be executed Box 68760, P.O.1 signed by the a d be detached for of Vital Records, peen within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s Hospital or Attending Physiclan: Division

BA11+1

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Hungen 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

130-32. Registrar's Signature

and manner stated.

Registrar

Physi /Me Exan

Funer Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be neaffied at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Regis

Social Security Number Social Security Num	County of Death County of Death County of Death County of Death DOVTEDMENS 9. Birthplace (State or Foreign Country) Connecticut 10d. Inside City Limits Large 2 No tizen of What Country? U.S. 14. Race - American Indian, Black, White, etc. Ascident American Sind of Business/Industry ail or Town, State, Zip Code) cocation - City or Town, State cocale, MD 20018		
A Facility Name (If not institution, give street and number) A Facility Name (If not institution) A Facility Name (If not institutio	County of Death County of Death County of Death County of Death DOVTEDMENS 9. Birthplace (State or Foreign Country) Connecticut 10d. Inside City Limits Large 2 No tizen of What Country? U.S. 14. Race - American Indian, Black, White, etc. Ascident American Sind of Business/Industry ail or Town, State, Zip Code) cocation - City or Town, State cocale, MD 20018		
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5. Social Security Number 0.48 - 50 - 7421 Usual Residence of Decedent 10e. Street and Number or Rural Route Number. City 10e. Street and Number or Rural Route Number. C	9. Birthplace (State or Foreign Country) Connecticut 10d. Inside City Limits Yes 2 No	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. City 10c. State 10c. State 10c. City, Town or Location 10a. City 10c. State 10c. St	Town, State, Zip Code) or Town, State, MD Connecticut 10d. Inside City Limits Insi
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Security of the property of the place of Disposition Security	cind of Business/Industry ail or Town, State, Zip Code) Ocation - City or Town, State coale, MD 20018		
17. Father's Name (First, Middle, Last) Henry L. Gaines 19a. Informant's Name/Relationship (Type. Print) Arlene G. Shabazz-Sister 19b. Mailing Address (Street and Number or Rural Route Number, City.) Arlene G. Shabazz-Sister 20a. Method of Disposition 1 Burial Mailing Address (Street and Number or Rural Route Number, City.) 20a. Method of Disposition 1 Burial Mailing Address (Street and Number or Rural Route Number, City.) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11-17-09 River Calle Park Crematory 21. Signature Funeral Service Licensee Incomplete Park Crematory 22. Name and Address of Facility 23a. Part 1. Inter the disease, or implication to accuse on each line. 25d. Place of Disposition (Name of cemetery, crematory or other place) 22. Name and Address of Facility 23a. Part 1. Inter the disease, or implication to accuse on each line. 25d. Place of Disposition (Name of cemetery, crematory or other place) 27d. Place of Disposition (Name of cemetery, crematory or other place) 28d. Place of Disposition (Name of cemetery, crematory or other place) 29d. Place of Disposition (Name of cemetery, crematory or other place) 11-17-09 River Called Park Crematory 20b. Place of Disposition (Name of cemetery, crematory or other place) 21-17-09 River Called Park Crematory 22. Name and Address of Facility 24. Do not enter the mode of dying, such as cardiac or respiratory arrest, showly or cemetery crematory arrest, showly or cemetery crematory or other place) 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, showly or cemetery crematory or other place) 34a. Part 1. Inter the disease or cemeter place the death. Do not enter the	or Town, State, Zip Code) Ocation - City or Town, State coale, MD 20018		
17. Father's Name (First, Middle, Last) Henry L. Gaines 19a. Informant's Name/Relationship (Type. Print) Arlene G. Shabazz-Sister 19b. Mailing Address (Street and Number or Rural Route Number, City.) Arlene G. Shabazz-Sister 20a. Method of Disposition 1 Burial Mailing Address (Street and Number or Rural Route Number, City.) 20a. Method of Disposition 1 Burial Mailing Address (Street and Number or Rural Route Number, City.) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11-17-09 River Calle Park Crematory 21. Signature Funeral Service Licensee Incomplete Park Crematory 22. Name and Address of Facility 23a. Part 1. Inter the disease, or implication to accuse on each line. 25d. Place of Disposition (Name of cemetery, crematory or other place) 22. Name and Address of Facility 23a. Part 1. Inter the disease, or implication to accuse on each line. 25d. Place of Disposition (Name of cemetery, crematory or other place) 27d. Place of Disposition (Name of cemetery, crematory or other place) 28d. Place of Disposition (Name of cemetery, crematory or other place) 29d. Place of Disposition (Name of cemetery, crematory or other place) 11-17-09 River Called Park Crematory 20b. Place of Disposition (Name of cemetery, crematory or other place) 21-17-09 River Called Park Crematory 22. Name and Address of Facility 24. Do not enter the mode of dying, such as cardiac or respiratory arrest, showly or cemetery crematory arrest, showly or cemetery crematory or other place) 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, showly or cemetery crematory or other place) 34a. Part 1. Inter the disease or cemeter place the death. Do not enter the	or Town, State, Zip Code) Ocation - City or Town, State Coale, MD 20018		
17. Father's Name (First, Middle, Last) Henry L. Gaines 19a. Informant's Name/Relationship (Type. Print) Arlene G. Shabazz-Sister 19b. Mailing Address (Street and Number or Rural Route Number, City.) Arlene G. Shabazz-Sister 20a. Method of Disposition 1 Burial Mailing Address (Street and Number or Rural Route Number, City.) 20a. Method of Disposition 1 Burial Mailing Address (Street and Number or Rural Route Number, City.) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11-17-09 River Calle Park Crematory 21. Signature Funeral Service Licensee Incomplete Park Crematory 22. Name and Address of Facility 23a. Part 1. Inter the disease, or implication to accuse on each line. 25d. Place of Disposition (Name of cemetery, crematory or other place) 22. Name and Address of Facility 23a. Part 1. Inter the disease, or implication to accuse on each line. 25d. Place of Disposition (Name of cemetery, crematory or other place) 27d. Place of Disposition (Name of cemetery, crematory or other place) 28d. Place of Disposition (Name of cemetery, crematory or other place) 29d. Place of Disposition (Name of cemetery, crematory or other place) 11-17-09 River Called Park Crematory 20b. Place of Disposition (Name of cemetery, crematory or other place) 21-17-09 River Called Park Crematory 22. Name and Address of Facility 24. Do not enter the mode of dying, such as cardiac or respiratory arrest, showly or cemetery crematory arrest, showly or cemetery crematory or other place) 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, showly or cemetery crematory or other place) 34a. Part 1. Inter the disease or cemeter place the death. Do not enter the	or Town, State, Zip Code) Ocation - City or Town, State Coale, MD 20018		
17. Father's Name (First, Middle, Last) Henry L. Gaines 19a. Informant's Name/Relationship (Type. Print) Arlene G. Shabazz-Sister 19b. Mailing Address (Street and Number or Rural Route Number, City.) Arlene G. Shabazz-Sister 20a. Method of Disposition 1 Burial Mailing Address (Street and Number or Rural Route Number, City.) 20a. Method of Disposition 1 Burial Mailing Address (Street and Number or Rural Route Number, City.) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11-17-09 River Calle Park Crematory 21. Signature Funeral Service Licensee Incomplete Park Crematory 22. Name and Address of Facility 23a. Part 1. Inter the disease, or implication to accuse on each line. 25d. Place of Disposition (Name of cemetery, crematory or other place) 22. Name and Address of Facility 23a. Part 1. Inter the disease, or implication to accuse on each line. 25d. Place of Disposition (Name of cemetery, crematory or other place) 27d. Place of Disposition (Name of cemetery, crematory or other place) 28d. Place of Disposition (Name of cemetery, crematory or other place) 29d. Place of Disposition (Name of cemetery, crematory or other place) 11-17-09 River Called Park Crematory 20b. Place of Disposition (Name of cemetery, crematory or other place) 21-17-09 River Called Park Crematory 22. Name and Address of Facility 24. Do not enter the mode of dying, such as cardiac or respiratory arrest, showly or cemetery crematory arrest, showly or cemetery crematory or other place) 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse on each line. 33a. Part 1. Inter the disease, or implication to accuse the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, showly or cemetery crematory or other place) 34a. Part 1. Inter the disease or cemeter place the death. Do not enter the	or Town, State, Zip Code) Ocation - City or Town, State Cale, MD 20018		
19a. Informant's Name/Relationship (Type. Print) Arlene G. Shabazz-Sister 20a. Method of Disposition 1 Burial Cremation 3 Removal from State 4203 Seatons Promise Dr., Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) Rivercale Park Crematory 21. Signature Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23a. Part 1. Inter the disease, or implication Line caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 25b. Place of Disposition (Name of cemetery, crematory or other place) 27c. Lamps and Address of Facility 27c. Lamps and Addres	ocation - City or Town, State coale, MD 20018		
Arlene G. Shabezz-Sister 20a. Method of Disposition Date Da	ocation - City or Town, State coale, MD 20018		
20a. Method of Disposition Date Date Date Cemetery, crematory or other place)	ocation - City or Town, State rotale, MD 20018		
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21. Signature of Funeral Service Licensee Lincoln 22. Name and Address of Facility Pornette & Assoc. Funeral Home 2504 3a. Part 1. Inter the disease, or implication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	20018		
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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Approximate Interval Between		
Due to (or as a consequence of): Sequentially list conditions, if air, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Onset and Death		
Due to (or as a consequence of):	_,, 30		
Due to (or as a consequence of):			
Due to (or as a consequence of):			
ledical plants and the second			
23b. Was decedent pregnant in the past 12 months? 1			
1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco			
1 □ Yes 2	use contribute to the cause of death?		
12	□ No 3 □ Probably 4 □ Unknown		
24a. Was an	24b. Were autopsy findings available		
autopsy performed?	prior to completion of cause of death?		
25. Was case referred to medical 26. Place of Death (Check only one)	1 □Yes Ź□No		
	6 □ Other (Specify)		
28a. Date of Injury 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how inju			
2 Accident investigation M 1 Yes 2 No			
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)		
O Cortifica 1 T Contract T the head of my lead to the lead of the			
1 Yes 2 No	i) and manner as stated. d place, and due to the cause(s)		
29b. Signature and title of certifier 29c. License number 29d. Da	ate signed (Month, Day, Year)		
D0060319 1	11,2009		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
DARCLE M HAMMEN 2101 PRINCEPTNING IT. (Tate 31. Date filed (Month, Pay, Year) 32. Registrar's Signature	6/ 111. 710.7		
tate NOV 1 7 2009 August 1. Aparts Signature 1	Hacy MAD 20832		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Wayne Rocky Julio Holder November 2009 10:30 P.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9041 Congress Place Prince Georges Landover If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) New BrookLyn, York 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) New Months 1**X** M 2 ☐ F Days Hours 060-44-6955 56 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1XYes 2 □ No Maryland Prince Georges Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9041 Congress Place 20785 United States 12. Was Decedent Ever in U.S. Armed Forces? March 1 X Yes 2 □ No 1977 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates: Dec.1979 1 ☐Yes 2X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Washington Metropolitan lementary/Secondary (0-12) College (1-4or 5+) Area Transit Authority 12th grade Metro Bus Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Allen Holder Stella Bonifacia Alfoiso 19a. Informant's Name/Relationship (Type. Print) (Daughter) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Bonifacia Holder 9041 Congress Place; Landover, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 13, 2009 20c. Location - City or Town, State Cheltenham, 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Maryland Cheltenham Veterans Cemetery; 4 ☐ Donation 5 ☐ Other (Specify) Maryland

Physician /Medical

Department of Health ar Important: If Item 27 is any Injury or other trau

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

Funeral Director

Completed by

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner physician and s the burial-transit

a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Perneral Director: After this certificate has been signed by the attending physician and elely filled in by the furneral director, page 2 should be detached for use as the burlan-transit

Division of Vital Records, P.O. Box 68760,

	21. Signature of Funeral Service Licens	iee,	22. Name	and Address of Facility ${f R}$.	N. Horton	Company	Morticians,			
	Sandelpl	1 D. Hoyles	Inc.;	600 Kennedy S	treet,N.W.	;Washing	ton,D.C.2001			
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.				<i>t</i> 7.	Approximate Interval Between Onset and Death			
	disease or condition resulting in death)	a. ATTHOSEL Due to (or as a conseq	endire Co	ardiovascu	for Aka	U Dis	ease			
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):								
dical Exa	resulting in death) Last	Due to (or as a conseq	uence of):							
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	I death 3 Ectopic			23d. Date of de Month	livery Day Year			
ted by PI	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the underlying	cause given in Part I.	23e. Did tobacc		o the cause of death? robably 4 Donknown			
Complet					24a. Was an autopsy performed? 1 ☐ Yes 2 ☑	death?	utopsy findings available completion of cause of			
Be	25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)					
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ [OOA Other: 4 In Nursing H	lome 5 🗶 Residence	6 ☐Other (Spe	ecify)			
ation:	27. Manne of Death 1.	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred				
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, street, factory)	ry, office	28f. Location (Street City or Town, Sta		ural Route Number,			
edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	/sician: To the best of my kno Iner: On the basis of examina and manner stated.	włedge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner a and place, and due	s stated. e to the cause(s)			
Σ	29b. Signature and title of certifier		2	9c. License number	29d. I	29d. Date signed (Month, Day, Year)				

140053971

29d. Date signed (Month, Day, Year)

. 2009

November /3

DHMH 17 Rev 1/2001

State

Registrar

Salvador Sylvester, M.D.; 255 Rockville Pike; Suite 125; Rockville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 1 7 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0$ For State Registrar/Amend#8.PenFHPCC11-13-09cn Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day 2009 **Physician** NOVEMBER LOWELL STEVEN HAMILTON 10:52 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1√2 M 2□ F 213-76-5774 50 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No PRINCE GEORGE'S CAPITOL HEIGHTS MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a or 2 USA 20743 4522 PINKARD PLACE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or itel 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE DISABLED 11th 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be WASHINGTON JAMES S. HAMILTON P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4522 PINKARD PLACE CAPITOL HEIGHTS, MARYLAND 20743 PAMELA D. HAMILTON/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/15/2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY : 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the Ks 156, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** FATAL CARDIAC ARRYTHMIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending I Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No death 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital To the Funeral 29a. Certifier 11 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 one) 29b. Signature and title of certifier 29c. License number 30. Na (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien (1) 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician 2:35 PM 6 2009 November Mary L. Inabinet /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Hyattsville Prince Georges Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 72 12/30/1936 Washington, D.C <u>240-54-1858</u> Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Hygiene. other then "naturel", or iteme 23s or 28s-f show ent. It a Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20011 6024 Sligo Mill Rd., N.E. Completed by Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: Black 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grants Technician Federal Government other permit. Pages 1 and 2 should be file Deperment of Health and Mental Hyg Important: If Item 27 ie marked other any Injury or other traumatic event, 2008. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sam Robinson Kate Price ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4706 68th Ave Hyattsville MD 20784 Pierre Inabinet/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 11-13-2009 Brentwood, MD 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 23a. Part1. Enter the description of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart frillium. List only one cause on each line. nances 3401 Bladensburg Rd Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Fin I disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed t d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

2♣ No 24a. Was an autopsy performed? certificate 1 Yes 217 No Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 21 No 1 Inpatient 2K ER/Outpatient 3□ DOA Pis 28c. Injury at Work? 28a. Date of Injury (Month, Day Year, 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours at To the Funerel D Medicai 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0026024 11/6/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington, D.C. 20017

State Registrar

Lester Miles, M.D.

1160 Varnum St. N.E. 32. Registar's Signiture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 9 38221 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month November Day 10 **Physician** วได้ถึง 9:35 pM Robert Patterson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Cambridge 109 Somerset Avenue 8. Date of Birth (Month, Day, Yea Oct. 7, 19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □XM 2 □ F 218-20-8496 83 Maryland Director Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. State 28a-f show be notified at 1X Yes 2 □ No Dorchester Cambridge Director MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 6 109 Somerset Avenue USA 21613 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medikal Exa<u>miner must 1</u> Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 XNo Specify: þ WWIT 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) lineman telephone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Radcliffe Jones Sr. Lyda Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) wife 109 Somerset Ave., Cambridge, MD Mary G. Jones Date 20c. Location - City or Town. State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Green Bank Cemetery 11/14/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility Thomas Funeral Home P.A. Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myc osenous **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any issuing to infinitely accuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence off Examiner burial-trar Due to (or as a consequence of) the attending physician the dornary Box 68760. pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 Probably 4 ☐ Unknown cate has been siç : page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an certificate has autopsy performe 1∐ Yes 2ÆNo 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 5 Pending investigation 1 🗋 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gertifier run 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Sute

32. Registrar's Signature

orche) tei

NOV 13

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Warylan		ertificate of		Reg. N		38222
	Physici	an	1. Decedent's Name (First, Middle	JOHN SON				2. Date of Death Month	Day Year	3. Time of Death
2	/Medi	al	4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death	Jovember	7 2009 4c. County of Deatl	0440 M
	Examir	ier	Dorchester	General Hosp	ital	Camb	pridae	1	Dorche	ester
	Funeral Director		5. Social Security Number	6. Sex 7. Age (In yrs. 1 ☐ M 2 ☐ F	last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea トセレルスト	9. Birth Co.	hplace (State or Foreign untry) th Carolina
	P.		Usual Residence of Decedent	10c Cit	y, Town or	Location		Centan	7.7 7.00	10d. Inside City Limits
	Maryland -f show lied at	tor	10a. State 10b. County	rchester	Car	shridae				1 Mes 2 No
士	with the la or 28a	Funeral Director	10e. Street and Number	*****	0470	10f. Zip Oode	. 12	10g. (Citizen of What Co	•
3	death w	eral	11. Marital Status	coln Terrac	.s. 13	2/6 3. Was Decedent of H		cify Yes or No-	2L 5 A	
Johnson Maryland 21215-0036	ours after ral', or ite Examine	by	1 □ Never Married 2 □ Married 3 ₩ Widowed 4 □ Divorced	If Yes, Give		1 ☐ Yes 2 █ ÎÑo			Specify: Black	ack
15-0	"natural"; "dical Exa	letec	15. Deceden (Specify only highe	nt's Education st grade completed)	16a. Dec	cedent's Usual Occup ve kind of work done b. DO NOT use retire	oation during most of workin d)	g 16b.	. Kind of Business/	Industry
212	e filed within all Hygiene. I other than "I went, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	l	Mestia			Meone e	Ise's home
10500	be filed tal Hygid d other event, tl	To Be C	17. Father's Name (First, Middle,	0	•		1 1	(First, Middle, Maid	len Surname)	
ohr aryla	2 should be a nand Mental lis marked o raumatic eve	오	19a. Informant's Name/Relations		19b. Ma	ilina Address (Street	and Number or Rural	, ,000	v or Town, State, 2	Zip Code)
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Ollie . Baltimore,	of of		20a. Method of Disposition 1 Burial 2 Cremation	2 D Bomoval from State	cemetery, ci	position (Name of rematory or other pla	ce)		Location - City or	Town, State
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) Ba	permit. Departr Importa any inji		Divelle	C. Henry	ļ.,	Henry F	ess of Facility Uneral Facility Shington	sti Cam	bridge	MD. 21613
			23a. Rart1. Enter the disease, or shock, or heart failure. List	r complications that caused the deat tonly one cause on each line.	h. Do not e	enter the mode of dyi	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SMALL		NEL -	INFARC	TION		Oliset and Deau
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	ertifica ling ph e as th		IF FEMALE:	000 16 0110000 06 01000						
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of the second	al death	3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	ey .		23d. Date of del Month	livery Day Year
Δ.	as that gned by		Part II. Other significant conditi	ons contributing to death but not res	sulting in the	e underlying cause gi	ven in Part I.	23e. Did tobacc	1	the cause of death?
ord	require een sig nould b	ted l				· ·		1 Yes	,	robably 4 Unknown
Division or Vital Records,		Completed by						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of 2 □ No
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n or	Attending Physician: r death. ector: After this certifics by the funeral director, I	on: To	27. Manner of Death 1 Natural 5 Pendir	28a. Date of Injury	28b. Time Injur	of 28c. Inju		28d. Describe how in		ony)
siol	ttendli Jeath. Itor: A the fu	catic	2 Accident investi 3 Suicide 6 Could	not be 280 Place of injury. At h	ome form]Yes 2□No	8f. Location (Street	t and Number or P	ural Route Number
Div	al or A s after o	Sertif	4 ☐ Homicide determ	building, etc. (Speci	fy)	street, factory, office		City or Town, Si	tate)	ara Houte Hambol,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Certification:	29a. Certifier 1 Certifyli (Check only 2 Medical one)	ng Physician: To the best of my kno I Examiner: On the basis of examina and manner stated.	owledge, de ation and/or	eath occurred at the t r investigation, in my	ime, date and place, a opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certified	obla			se number 067463		Date signed (Mont	
				who completed cause of death (Item 219 South Washin			MD 21601			
		ate	31. Date filed (Month, Day, Year,) OO Desistante Cina	ahura		TID 21001			
	Regist	rar	NOV A&	2009 Alexandra Sign	p. 14	7614				

DHMH 17 Rev 1/2001

NOV 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 38223 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 06-46 PM Son 06 2009 James Henry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Dorcheste Social Security Number da Dorchester General 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1**12** M 2□ F Days Hours Min. 3-42-0312 Director Marylana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 PYes 2 □ No item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examination must be mailting Director 10e. Street and Number 10g. Citizen of What Country? Street. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 WYes 2 No 196 9 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 WNo If Yes, Give Year or Dates: Specify. Be Completed by Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vaving Contractor ing Specialist 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Butler Benjamin Pages 1 and 2 should Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nda Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location City or Town, State Important: If it any injury or c 1 Burial 2 □ Cremation 3 □ Removal from State 18/09 Cemetery Hurlock, MD Veterans 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Henry Funeral Home, P.A.
510 washington St. Cambridge MD. 2/6/3 23a. Bort 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner epatitis Tears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 □Yes 2 □No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe Diabeles 2 No 3 Probably 4 Unknown 1 🗌 Yes has been 24a. Was an autopsy performed? Yes 2 No this certificate 1 □ Ýes_ Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Matural 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 830 Tuhammad 31. Date filed (Month, Day, Registrar's Signature State Registrar

			For State Registrar	State of Ma	aryland	-	artmen <i>rtificat</i> (ind M	lental Hy	/giene Reg. No		٠,	38224
	Dhusia		1. Decedent's Name (First, Middle, L	ast)							2. Date of D	eath Da	ıv Yea		3. Time of Death
	Physic /Medi		MARY E	. JONES							NOV.	12,	2009		l2:45 P ^M
	Exami	ner	4a. Facility Name (If not institution, grace CHARLES COUNTY N		ЕНАВ.	CENTE		Town, or A PL	Location of	f Death			CHARLE		UNTY
	Funeral Director			Sex 7. Ag	e (In yrs. Ia 68	as <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D 8-14-1	orth av. Year) 941	9. E	Birthplace Country RG II	e (State or Foreign NIA
	e Maryland sa-f show	Director	Usual Residence of Decedent 10a. State 10b. County DC			, Town or Lo								10d.	Inside City Limits 1
	th with th		10e. Street and Number 3448 - 21ST STR	EET, S. E.			10f. Zip		020				tizen of What	Country	?
920	a within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28s-1 show The Medical Examinar must be portified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent Amed Forces? 1 Tyes 2 The If Yes, Give Year or Dates:			Vas Deced f Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Al Black, W Specify:		
Baltimore, Maryland 21215-0036	within liene. r than "	Completed	15. Decedent's 8 (Specify only highest g. Elementary/Secondary (0-12) 8TH GRADE	Education ade <i>completed)</i> College (1-4or 5	5+)	16a. Deced (Give life. L	kind of wor DO NOT us	k done d e retired	ation during most)	of worki	ing	GREA	Cind of Busine ATER SC MUNITY	UTH	EAST
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Mary	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship KELVIN J. WATSON				-		nd Number PLACE				or Town, State		•
more,			20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 ↑ 4 □ Donation 5 □ Other (Spec		CB	ace of Dispos metery, crem	natory or of	her place			Date L-09		ocation - City		State
Balti	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Lice			22	. Name an	d Addres	s of Facility	PI	NCKNEY-	-SPAN	IGLER F	'.Н.	002-5236
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68760, ifficate be executed	ficate be executed physician and sthe burial-transit	edicai Examiner	d any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	c	a consequ	ence of):									
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ita	ian: rtifica stor, p	Be C	25. Was case referred to medical						26. Place	of Death	1 Yes		1 L Y	es 2] INO
	hyaician: nis certifica I director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🔲 Inpatie	nt 2 🗆 E	P/Outpatient	3 DO	A Othe		-		-/	6 Other (Sp	oecify)	
Division of	I or Attending Ph after death. Director: After thi I in by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Y _{Year)}	28b. Time of Injury	28 M	Bc. Injury Work 1 🗀 Y	at	2	28d. Describe				
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director. After this certific completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not to determined		ry - At hon :. (Specify)	ne, farm, stre	et, factory,	office		2	28f. Location (City or To		nd Number or e)	Rural Ro	oute Number,
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred a estigation,	it the tim in my op	e, date and inion, death	place, a	and due to the ed at the time,	cause(s) date and) and manner d place, and d	as stated ue to the	d. cause(s)
)	To t within	Σ	29b. Signature and title of certifier	7 Amd	war	J.			number 616	14			te signed (Mo		Year) (6 th, 2009.

CR 15

State Registrar RAVINDER K. SINDWANI, M. D.
31. Date filed (Month, Day, Year)

NOV 1 7 2009

August J. 5 GARRETT AVENUE LA PLATA, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 10, 2009 **Physician** 1745 Vovember LAKISHA JONES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S 13001 OLD STAGE COACH ROAD #1318 LAUREL 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🛣 F MARYLAND 25 MAY 11 1984 Director 214-31-1796 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examment in must be mailted at 1X Yes 2 □ No Director PRINCE GEORGE'S LAUREL MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13001 OLD STAGE COACH ROAD #1318 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No ARMY If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify. Specify: BLACK ρ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH PRIVATE GENERAL MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHIRLEY M. COSBY GILBERT JONES JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13001 OLD STAGE COACH ROAD 1318 LAUREL, MARYLAND 20708 SHIRLEY M. JONES Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/20/2009 LOTHIAN, MARYLAND MOSES CEMETERY J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any least grant the late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examiner law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Į Month Day Year 5 Other (specify) ned by the a detached f ☐Yes 2☐No P.O. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the inector, page 2 standard performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred Hung hers ef at home 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Injury 739 5 Pending investigation 1 Natural Novemba 10,2009 1 ☐Yes 2 No 2 Accident completely filled in by the 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 33500 STAJEC SACK ROAL LAWER 4 Homicide home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital 31. Date filed (Month, Day Year) NOV 1 7 2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 10a,b,c,e,f, per inf/nn,g903,05/04/2010dhb

Reg. No.

Certificate of Death

Reg. No. For A State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Month Physician/ 05 8:45 Losev James Keene Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery Sligo Creek Nursing and Rehab. Ctr Silver Spring If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) 1 🙀 M 2 🗆 F Months Days Hours 01/11/1926 Director 254-34-2828 83 Usual Residence of Deceden 28a-f shov 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at **Funeral Director** MD Montgomery 1 X Yes 2 No Takoma Park -DC Washington 10e. Street and Number
7525 Carroll Avenue 5 10f. Zip Code 10g. Citizen of What Country? 23a 20912 5229 Chillum Place, NE 20011 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1

Yes 2 □ No 1945—
If Yes, Give 1046 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 'natural", Completed 3 Widowed 4 Divorced 1946 Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) **Military** Federal Government Elementary/Seconday (0-12) College (1-4 or 5+) DOD 4 Personnel Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ၉ Samue1 Keene Inez **Jones** permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar any injury or other traumati once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5229 Chillum Place, NE Washington, DC 20011 <u> Irene W. Keene - Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery 11/13/2009 4 Donation 5 Other (Specify) Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brentwood, MD Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Stroke Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant 9 Unknown 1 ☐ Yes ≥ L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No **Hypercholesterolemia** 24a. Was an autopsy performed? Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Certificate: To 1 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 11/11/2009 D45471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yeheyis Negussie, 1111 Spring St., #214 Silver Spring, MD 20910 MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month. Day. N

NOV 1 2 2009

State of Maryland / Department of Health and Mental Hygiene 38227 1 - For State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 8, 2009 **Physician** Kidwell Sr. Franklin 9:35 am[™] Lane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 415 Greene Street Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) May 13, 1945 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 232-74-3805 64 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Allegany Cumberland 1 □¥es 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 415 Greene Street USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ Xo If Yes, Give Year or Dates: Specify 2 3 Widowed 4 Divorced white Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the M any Injury or other traumatic event, the M any Enges. Coflege (1-4or 5+) brick layer self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ray Nibrod Kidwell Mary Virginia Hutchenson ۵ 19a. Informant's Name/Relationship (Type. Print)
Peggy Kidwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
415 Greene Street Cumberland MD 21502 wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/11/2009 LaVale MD 4 ☐ Donation / ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 se, of complications that caused the death st only one cause on eacy line. Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease shock, or heart failure. L Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cau + (First disease or constion resulting in de rh) **Physician** va e hour /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 □Yes 2 ☑No ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 29a. Certifier within 24 hou

To the Fune

completely fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person w completed cause of death (flem 23a) (Type, Print) WAGONE BISHOP WALSH DR CUMBERIANO, MD 21503 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 38228 For State 11-16-09 Registrar Amend#23a. Prt. 1. Lineb. PerPhys. Poor Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** OIT AM membe 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimon 7. Age (In yls. last birthday) JOHNS 8. Date of Birth (Month, Day, Jan. 11, 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Rhode Island 81 038-14-7960 Director Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c City Town or Location 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Experiment past be mitthed at 1 ☐ Yes 2 No Director Virginia Fairfax Alexandria 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death with United States 22310 5706 Overly Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Unknown 1 □Yes 2 No Specify <u>Ş</u> Specify: Caucasian 3K Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed withinment of Health and Mental Hygiene.
ant: If item 27 is marked other than "
ury or other traumatic event, "In Men Elementary/Secondary (0-12) College (1-4or 5+) -11-Elevator Mechanic Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuel Leite Isabelle Brum ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn F. Kidd - Daughter permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 5706 Overly Drive Alexandria, VA 22310 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Comfort Cemetery Nov. 7, 2009 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan Drive Alexandria, VA 22315 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Respiratory arrest Sequentially list conditions, if a.y. leading to firm class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Metastatic burial-trar Due to (or as a consequence of): physician sthe burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown Δ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, è 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably been si Completed 24b. Were autopsy findings available prior to completion of cause of death? law 24a. Was an certificate has page 2 autopsy Physiclan: The 1 ☐Yes 2 ☐ No Division of Vital 1 □Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) . Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending Injury n 24 hours after death.

le Funeral Director: Aff
bletely filled in by the fur investigation 1 □Yes 2 □No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 29c. License number

JR 4 State

Date filed (Month, Day, Year)
NOV 1 6 2009

32. Registrat's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

600 U. Wolfest Baltimore

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1 9 3 8 2 2 9										
	Physicia		1. Decedent's Name (First, Middle, Last) Paul Edward Luken		2. Date of Death		3. Time of Death 12:30 P M						
	Medic Examin		4a. Facility Name (if not institution, give street and number) 9306 Locksley Road	4b. City, Town, or Location of Death Ft. Washington		4c. County of Death Prince Geor							
I	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You March 24,	9. Birthpl Counti	ace (State or Foreign Ohio						
	aryland a-f show fied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's Ft. Wa	ocation Ashington		10	nd. Inside City Limits						
	ith the Ma 23a or 28a at be notifi	ral Dire	10e. Street and Number 9306 Locksley Road	10f. Zip Code 20744	10	g. Citizen of What Count USA							
(0	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- partical Rican, etc.)	14. Race - America Black, White, e							
Baltimore, Maryland 21215-0036	hours aft 'natural", dical Exar	oleted t	15. Decedent's Education 16a. Dece	1 Yes 2 No Specify: edent's Usual Occupation be kind of work done during most of work	kina 10	Specify: Wh	uite ustry						
12121	d within 72 lygiene. ther than ' nt, the Me	Federal Gov	vern m ent										
yland	uld be file Mental H narked of natic ever	To Be	17. Father's Name (First, Middle, Last) Clarence Luken	iden Surname)									
, Mar	nd 2 shor lealth and m 27 is n		Phyllis Luken / Wife 9306	ity or Town, State, Zip Coon, MD 207									
imore	Page 1 ament of Hament of Hament of Hament If ite		MATERIAL E - CIONATION C - HOMOVALION CIACC	osition (Name of matory or other place) Nat. Cemetery 1/14,	.	Oc. Location - City or Tov							
Balt	permit Depart Import any inj		Kert Taken	s Funeral Home ryland 20745	P.A.								
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition LUNG CANCER													
	Medical Examiner		resulting in death) Due to (or as a consequence of):										
	cuted nd ransit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on mijury that initiated events										
09	ficate be executed g physician and as the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of): d.										
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year						
, P.O.	es that th signed by I be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the							
cords	law requii has been e 2 shoulc	Completed			24a. Was an autopsy	24b. Were autops	sy findings available pletion of cause of						
tal Re	cian: The ertificate ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	performe 1 ☐ Yes 2X k only one)		. □ No						
Division of Vital Records,	ding Physi th. After this c funeral dira	cate: To	1 Yes 2XX No		ome 5 XX Residence 28d. Describe how	ce 6 Other (Specify) injury occurred							
Divisio	al or Atter s after dea I Director: d in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural F State)	oute Number,						
_	ne Hospital o n 24 hours aff ne Funeral Di pleted filled in	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death of the control of th	stigation, in my opinion, death occurred a	t the time, date and p	place, and due to the caus	e(s) and manner stated.						
	Vota Vith Com		29b. Signature and title of certifier 29c. License number D 23743 November 11, 200										
1	12+		30. Name and address of person who deficiency cause of death (Item 23a) (Type, Martin D. Weltz 7525 Greenway Ct. Dri		20770								
	Stat Registra	·	31. Date filed (Month, Day, Year) NOV 1 2 2009 August 32. Registrer's Sign Rure										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 Physician/ 1510 Granville V. Lambert 11 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Clinton Southern Maryland Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 ☑ M 2 ☐ F (Month, Day, Year) 2/30/1937 Funeral Min. Hours VΑ Director 230-50-5523 Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County Director 1XX Yes 2 No Clinton MD PG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20735 9211 Stuart Ln Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black White, etc. 1 Never Married 2 Married þ Specify: Black 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 3 K Widowed 4 ☐ Divorced "natural" Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Hygiene. **other than** "ı WASHINGTON SUBURBAN College (1-4 or 5+) Elementary/Seconday (0-12) SANITARY COMMISSION Laborer 12th grade if Health and Mental Hygie item 27 is marked other other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Clara Harts Bing Lambert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 1515 Redford Dr. Fort Washington MD 20744 Dale Lambert/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State Harmony Mem. Park: 11/14/2009 | Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Graft Infection Examiner tevio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Day Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Tunknown Kena Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 -N 1 ☐ Yes 2 Ho 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical examiner? Other: 1 ☐ Yes 2 ₺ No 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27, Manner of Death work? 1 Hatural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practiciner: To the basis of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner stated. within 2. DO037066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 88 O ton (till Rd# 701, O ton Itill MID 2074S 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	rtment of F rtificate of I	lealth and l Death	Mental Hyg	iene 200	9 38231	
			1. Decedent's Name (First, Mic	idle, Last)					2. Date of Deat Month		3. Time of Death	
Н	Physicia /Medic		Gene	Masters					Novembe	r 7, 2009		
-	Examin		4a. Facility Name (If not institut	, ,	umber)		4b. City, Town, or	Location of Death	1	4c. County of D	eath	
			Genesis Heal				Waldo			Charl		
	Funeral Director		5. Social Security Number 239–22–2036	6. Sex 1 X M 2 □ F	7. Age (In yrs	. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 12	,1919 9.	Birthplace (State or Foreign Country) NC	
	w		Usual Residence of Decedent 10a. State 10b. Cour	ntv	10c. C	itv. Town or Lo	cation				10d. Inside City Limits	
	//arylan f show	<u>.</u>		arles		Waldor					1 XYes 2 No	
	the 1	rec	10e. Street and Number	11168		waldul	10f. Zip Code		1	0g. Citizen of What	Country?	
	3a oi	Funeral Director	19060 Weymout	h Court			206	603		USA		
	death ms 2	ner	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13. \	Was Decedent of H		pecify Yes or No-	14. Race - A	American Indian,	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Medical Erachinal rutt be indifficult	by	1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divorc	If Yes G	2 ∑X No aiv <i>e</i>		fYes, specify Cuba	an, Mexican, Puerti Specify:	o Hican, etc.)	Black, W Specify:	/hite, etc. White	
5-0	72 ho	etec	15. Deced	ent's Education hest grade completed	n	16a. Deced	lent's Usual Occup	ation	kina	16b. Kind of Busine	ess/Industry	
121	ithin ne.	Completed	Elementary/Secondary (0-12		/ (1-4or 5+)	life. I	DO NOT use retire of	d) mest of w or	Na 19			
2	led w Tygie her ti		12 17. Father's Name (First, Midd)	(n. / net)		Sal	esman	10 Mothor's Non	o /First Middle 8	Laundr	ТУ	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, II a. M) Be	Aaron Masters						e (First, Middle, Maiden Surname) Tipton			
Z	thould Me mark	၀	19a. Informant's Name/Relation			19h Mailir	a Address (Street			; City or Town, Stai	te Zin Code)	
Ma	nd 2 s lith ar 27 is r trau		Gary Masters/				Cachalot				ie, zip oode)	
ľe,	of Health of Health of Item 27 is		20a. Method of Disposition	Jon	20b.	_	sition (Name of natory or other place			20c. Location - City	or Town, State	
E	Page nent c int: If		1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		n State		ing Ceme	: 11/	2/2009	Lacey Sp	ring, VA	
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or ot		21. Signature of Funeral Servi	ce Licensee	I	22	. Name and Addre	ss of Facility Hu	ntt Funer	al Home	MD 20601	
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4.	Physician /Medical		shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	a	LYA	APH C	XAA			L	Interval Between Onset and Death	
Examiner Sequentially list conditions b.												
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	4	(1						
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8760,	ate be nysicia ne bui	dical		d								
9	rtifica ng ph as th	(O)	IF FEMALE:									
.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 🔲 Live	utcome of pregree birth 2 Fet sgnant at time of known	al death 3	Ectopic pregnand Other (specify)	ey .		23d. Date of Month	f delivery Day Year	
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Records,	law re as be 2 sho	Completed							24a. Was a	n 24b. Were	e autopsy findings available r to completion of cause of	
m m	:: The law icate has i ; page 2 s	l M	,						perform	ned? deat	th? Yes 2 No	
Vital	nystcian: Th nis certificate director, pag	Be (25. Was case referred to medi examiner?					26. Place of Dea	ath (Check only on			
of \	Physic r this c ral dire		1□Yes 2XNo		Inpatient 2	_		4 Nursing F	lome 5 ☐ Reside	ence 6 Other (Specify)	
'n	ding F h. After funera	ion	27. Manner of Death 1 Natural 5 □ Pen	ding (Mo	e of Injury onth, Day, Year)	28b. Time of Injury	Wor	k?	28d. Describe ho	ow injury occurred		
isio	Attendideath. ctor: A cy the fu	icat	3 ☐ Suicide 6 ☐ Cou	stigation	ne of Injury - At I	nome form etc	M 1 □ eet, factory, office	Yes 2 □ No	28f Location (C)	troot and Number o	or Pumil Pouto Number	
Division	ital or A	Certification: To	4 Hornicide	buil	ding, etc. (Spec	cify)			City or Town	n, State)	r Rural Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certification (Check only one) 2 Medic	fying Physician: To the cal Examiner: On the and ma	he best of my kr basis of examinanner stated.	nowledg <i>e</i> , deat nation and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manne late and place, and	er as stated. due to the cause(s)	
	To t With To tl	Ž	29b. Signature and title of cert	fier			29c. Licens	se number	- K	9d. Date signed (M	Nonth, Day, Year)	
	44		30. Name and address of pers	on who completed car	use of death (Ite	em 23a) (Type,	Print) (1)	UE CERC	782 W	ALDON-	, Md accor	
	Sta Registr		31. Date filed (Month, Day, Ye		Registrar's Sign	nature A.	park					
					100,000	7-1	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State of Mary Registrar	land / Depa <i>Cert</i>	rtment of H	ealth and Me eath	ntal Hygiene Reg. No		38232	
Phys /Me	ician dical	1. Decedent's Name (First, Middle, Last) Franklyn	Mc	gee	1	Date of Death	ल राज्य	3. Time of Death	
Exam Funera		1 X IM 2□ E	n yrs. last birthday)	Baltimore If Under 1 Year Months Days	City	Date of Birth (Month, Day, Year)	Country	ce (State or Foreign	
Directo	or	Usual Residence of Decedent	84 Yrs. Oc. City, Town or Loca Bowie		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	May 13, 1	925 Penns	ylvania d. Inside City Limits 1 🕱 Yes 2 🗆 No	
aryiand 21213-UU30 should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umetic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 12202 Fleming Lane 11. Marital Status 12. Was Decedent Ever	rin U.S. 13. W	10f. Zip-Code 20715	panic Origin? (Specify		tizen of What Country USA 14. Race - American		
UU36 Tours after d Trail, or iten	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 19	943-46	☐ Yes 2X No	panic Origin? (Specify, Mexican, Puerto Rici		Black, White, etc. Specify: Whit	e.	
Z I Z I 3-0036 d within 72 hours aft jiene. r than "natural", or the Medical Examir	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	(Give k	ent's Usual Occupa ind of work done di O NOT use retired) ncial Con	uring most of working		Kind of Business/Indu Retail	stry	
yland yland buld be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) Thomas C. McGee				Rittenhou	ıse		
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship (Type. Print) Kevin D. McGee / son 20a. Method of Disposition		2 Fleming		wie, MD	or Town, State, Zip C 20715 .ocation - City or Tow		
t. Pa tmer tmer tant:	ouce.	1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Loensee	Bayview (Crematory Name and Address	11/6/2 s of Facility Bea	ll Funera		D	
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्व के है	ertification: To B	1 Yes 2 No Hospital: 1 Inpatient 27. Magner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient ar) 28b. Time of Injury	28c. Injury Work?	at 28d	5 ☐ Residence	6 ☐ Other (Specify) ury occurred		
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	0	4 Homicide determined building, etc. (S	y knowledge, death	occurred at the time	e, date and place, and	City or Town, State	s) and manner as sta	ted.	
To the Hospital or within 24 hours after To the Funeral Dir.	Medical	(check only one) Medical Examiner: On the basis of example and manner stated 29b. Signature and title of ceptifier	amination and/or inve	estigation, in my op	inion, death occurred	at the time, date at 29d. Da		the cause(s)	
SH		30. Mame and address of person who completed cause of deat	h (Item 23a) (Type, F					MD. 21287	

State

31. Date filed (Month, Day, Year) NOV 1 0 2009

Registrar

			For State	State	of Marylar		artment rtificate			and Mo				20222
			Registrar 1. Decedent's Name (First, Mi	ddle, Last)			uncate	OIL	Jeaui		2. Date of De		2009	38233 3. Time of Death
	Physici /Medi		Anna Marie	Mocca							Month November	er 1	0, 2009	10:30 P ^M
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		×	15137 Vantage 5. Social Security Number	Hill Road	7. Age (In yrs.	la at hirthday			princ		8. Date of Bir		ntgomer	
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	th with	ralD	15137 Vantage	Hill Rd.			209	06			1	USA		
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5-0	72 ho	eted	15. Dece (Specify only hig	dent's Education thest grade completed)	16a. Dece	dent's Usual kind of work	l Occupa	ation Jurina masi	t of working	7	16b. Kind of Business/Industry		
121	within ene. than "	ldm	Elementary/Secondary (0-12	T .	(1-4or 5+)	life. l	DO NOT use	e retired))	co. worming	,	Dot	ail Sto	
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ylar	Menta Menta arked atic ev	To B	Francis Scarp	aci					Rose	Flor	ence M	arto	cci	
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altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Crematic 4 ☐ Donation 5 ☐ Other	Place of Dispo cemetery, cren nal Jou				Da 7 11/			cation - City or	•		
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Serv	Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Crematic								ce]	P.O. Bo	x 784
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8760,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to	(or as a conseq	uence of):								
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Vital	s certif	Be C	25. Was case referred to medi examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	LED/O		Othe	r-		Check only o			<u> </u>
Jo u	ig Phys ter this neral dii	n:T	27. Manner of Death	28a. Date	of Injury ofth, Day, Year)	28b. Time of Injury		c. Injury Work	7 🗆 140		e 5 A Resi Bd. Describe I		Other (Spe	ecify)
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1X Certification (Check only one) 2 ☐ Medication Medication (Check only one)	ying Physician: To the al Examiner: On the and mar	e best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurred a vestigation, i	it the tim in my op	ne, date an pinion, dea	nd place, au th occurre	nd due to the d at the time,	cause(s) date and	and manner a place, and due	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of cert	fier May (M	D,		License 8503					e signed <i>(Mont</i> ember 1	
	6		30. Name and address of pers Piyapong Vong	kovit, M.D.				ane i	Larac	o, MD	20774			
	Sta Registr		31. Date filed (Month, Day, Year) 3 2009 32. Registrar's Signature Survey D. Sparks											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Pi line c. PII & 25 per ME 8898 12/17/09 TT

State of Maryland Department of Health and Mental Hygiene 2 () () 9 38234 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year MAKELL 08200 PM Nov 05 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Harbor 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 218-48-5818 1 ☐ M 2 🖼 F 63 Days Yrs Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Anne Arunde urnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Warwickshire Lane USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 □No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Keeping Hote 17. Father's Name (First, Middle, Last) Holliday Sv. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Apt. G Warwickshire Lane Glen Burnie, avoletta Makell 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State harles thomas Men. St. Michaels, 14/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Henry Funeral Home, 510 washingtonst MD.21613 washington st. Cambridge SUL 23a. Parth. Enter the disease, or complications that caused the fleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic injury Degin 1 dad disease or condition resulting in death) Due to (or as a consequence of): probled resussitation with ardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic obstructive pulmonary disease Y MEDICAL EXAMINER Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Lung cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 🖬 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
XYes 2210 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

/Medical Examiner be executed Box 68760, P.O.

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Examiner

Physician/Medical

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Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it will deal Examinate institute and once.

Physician

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funeral

completely filled in by the

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physician

altimore, Maryland 21215-0036

of Vital Records,

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this Division

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(Check only one)

29b. Signature and title of certifier

29c. License number RESODO 29d. Date signed (Month, Day, Year) November, 05,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yasir Hamad

3001 S. Hanower 32. Registrar's Signature

Baltimore, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 10 11 2:55 A M McLAUGHLIN JAMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HYATTSVILLE ST. THOMAS MORE NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 06 30 1934 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. X□M 2□F NORTH CAROLINA Director 297 32 0882 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at MD PRINCE GEORGES GLENARDEN 1 Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 20706 U.S.A. 8106 MARTIN LUTHER KING HWY. #633 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2 □No Specify: BLACK Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other than any injury or other traumatic event, Insulation Elementary/Secondary (0-12) College (1-4or 5+) D.C. GOVERNMENT TRUCK DRIVER 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SMITH McLAUGHLIN ELIZA DANIEL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8106 MARTIN LUTHER KING HWY. #633 GLENARDEN 706 19a. Informant's Name/Relationship (Type. Print) MARY McLAUGHLIN/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEMORIAL 11-16-09 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOHN TWASHINGTON, DC 20017 LLC 21. Signature of Fundal Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immulate Cause (Final disease or condition resulting in death) **Physician** Artenoscientic Landiovascular 1 ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) P.O. signed by the a 1 ☐Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ icate has been sig page 2 should b 1 Tyes 2 No 3 Probably 4 Nnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 No or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after deau...

To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/200

(Check only one)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

001852

29d. Date signed (Month, Day, Year)

NOVEMBER 10 2009

09-08759 Larry D. Moore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death Reg. No.									
Physicia Nedical Exami	ın/ ner	1. Decedent's Name (First, Middle,Last) LARRY D. MOORE		Date of Death Month November							
		4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center	 b. City, Town, or Location of Death Cheverly 	ı	4c. County of Death Prince George's						
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 F 53 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Birthplace (State or						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. Street and Number 2712 BELLBROOK STREET 11. Marital Status 1 2 Was Decedent Ever in U.S. 13. Was 14 Yes 2 No 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) 12. College (1-4 or 5+) 16a. Decedent during model of the control of the contr	DON LLS 10f. Zip Code 20748 S Decedent of Hispanic Origin? (S as, specify Cuban, Mexican, Puertor S as, specify: Yes 2 X No specify: Yes 2 X No specify: Yes 18 Usual Occupation (Give kind of post of working life. DO NOT use ref. MOVER 18.Mother's Nam DOROTH' Address (Street and Number or BELLBROOK ST., sittion (Name of cemetery, her place)	pecify Yes or No- Rican, etc.) work done ired) e (First, Middle, M Y LEE WH Rural Route Numb	10d. Inside City Limits 1 Yes 2 No g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry LABOR FINDERS aiden Surname)						
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· 1 5		Name and audress of rerson who completed cause of death (Item 23a) Pamela E. Southall, MD	11 Penn Street, Baltimore,	MD 21201							
	tate	31. Date filed (Month, Savyyar) 32. Registyr's Signature 33. Registyr's Signature									
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Willie Mae McCray 4a. Facility Name (if not institution, give street and number) Charles County Nursing Home 5. Social Security Number 262-42-3038 10 Months 10			111/1/1	000							- ' /	1-1-	-{
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Willie Mae McCray 4a. Facility Name (If not institution, give street and number) Charles County Nursing Home Charles County Nursing Home I.a. Plata Charles County Nursing Home S. Social Security Number 262-42-3038 1	क	That y leading to find editate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Renal Failure Due to (or as a consequence of):											
Willie Mae McCray 4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles County Nursing Home 5. Social Security Number 262-42-3038 1		sliod, or hea Immediate Cause disease or condition	art failure. List on (Final on	a. Athero	ch line. Oscler r as a consec	otic quence of):	Cardi			or respiratory ar	rest,		Approxima Interval Be Onset and
Willie Mae McCray 4b. City, Town, or Location of Death Charles County Nursing Home La Plata Charles County Nursing Home La Plata Charles County Nursing Home La Plata Charles County Months S. Social Security Number 262-42-3038 Usual Residence of Decedent 10b. County Charles Waldorf 10b. County Charles Waldorf 10c. City, Town or Location Charles Waldorf 10c. City, Town or Location Charles Waldorf 10d. Lip Code 10d. County Charles Waldorf 10d. Lip Code 11d. Marital Status 11 Never Married 2 Married 3 William Min. Specify Yes or No- Hard Alexander or What Country? 11 Marital Status 11 Never Married 2 Married 3 Wildowed 4 Married 3 Wildowed 4 Married 11 States 12 Was Decedent Ever in U.S. Armed Forces? 11 Yes 2 Months Armed Forces? 12 Was Decedent Ferundan, Mexican, Puerto Rican, etc.) 13 Was Decedent of Hispanic Origin? (Specify Yes or No- Hard Alexander or Married 15 Specify only highest grade completed) 16 Elementary/Secondary (0-12) 17 Father's Name (First, Middle, Last) Morris Martin 19a. Informant's Name-Relationship (Type, Print) Titita McCray Daughter 20b. Place of Disposition 11 Burial 2 Marcenation 3 Removal from State 4 Donation 5 Other (Specify) Clinton, Maryla		21. Signature of F	M J.	Steway	t.I	I			St	ewart Fu NE Washi	nera ngto	1 Home, n, DC	Inc. 20019
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Willie Mae McCray Willie Mae McCray 4a. Facility Name (If not institution, give street and number) Charles County Nursing Home Month 10/30/09 10: 4b. City. Town, or Location of Death La Plata Charles County Charles County Charles		1 262 62 2020 12 10 10 10 10 10 10 10 10 10 10 10 10 10											_{uintry)} Georgia
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Willie Mae McCray Month Day Year 10/30/09 10:	er	,			,		7			1	4c. 0		
													10:3
1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time			o (i not, imadic, E	asi)								Year	3. Time o

			1 - For State Registrar	State of Marylan			t of Heal			giene (9 3	8239	
	Physici	an_	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	nth Day	Year	3. Time of Death	
	/Medic	al	Clate Moton, 4a. Facility Name (If not institution, give s			4b. City.	Town, or Loca	tion of Death	Novembe	er 6,200		:02 A. M	
*	Examir	ier	Prince George's 1	Hospital Cente		C	heverly	7			Georg		
	Funeral Director		577-50-5045	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days Ho	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da) 03/23/1		Country)	e (State or Foreign ick,S.C.	
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d.	Inside City Limits	
	Ba-f el	ector	Md. Howard	d	Ellic					10.00		1 Yes 2 No	
	3a or 2	by Funeral Director	10e. Street and Number 3197 Pine Orchard	d Lane		10f. Zip	2104	12		10g. Citizen of U.S	S.A.	t .	
	tems 2	uner		12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Deced	dent of Hispani offy Cuban, Me	c Origin? (Sp xican, Puerto	ecify Yes or No- Rican, etc.)	14. Rae Bla	ce - American ick, White, etc.		
900	72 hours after death with the Maryland 'natural', or items 23s or 28s-f show diesi Examinar must be notified at		1 Never Married 2 Married 3 Widowed 4 Divorced	1 Styes 2 □ No If Yes, Give Year or Dates: 60—	63	1□ Yes 2	2∳No Spe	ecify:		Specil	y: Blac	k	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show may follury or other traumatic event, the Medical Examiner must be notified at ance.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usua kind of wor DO NOT us	al Occupation rk done during se retired)	most of work	rin g	16b. Kind of B	Business/Indus	stry	
	filed wi Hygien other th		12th 17. Father's Name (First, Middle, Last)			Drive		Aother's Nam	e (First, Middle,		WAMATA		
Maryland	id be fental h	To Be	Clate Moton, Sr						e Mae Jo		116)		
ary	2 shoul and Me is marl		19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address			ral Route Numbe		, State, Zip Co	ode)	
	l and i		Brenda Moton/Wii		8312	The State of the S	and the first transfer of the facility of		er Marlb	oro, Md.			
nor	Pages nent of Hint: If Ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, crei	matory or o	ther place)	1					
Baltimore,	permit. Page Department important: if any injury o		21. Signature of Funeral Service License		esapeal	2. Name an	d Address of F	acility	11/10/0			,Md.	
8	88 5 8) any	M. Grall		4925_1	Burroug	ths Ave	& Sons	Washing	rton, D.		
	Dharaisias	2	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.			e of dying, suc	n as cardiac	or respiratory ar	rest,	Int	oproximate terval Between nset and Death	
	Physician /Medical		disease or condition resulting in death)	Respirator Due to (or as a consequence)		lure							
	Examiner	<u>_</u>	Sequentially list conditions,	CVA Due to (ur as a cunseq	and the								
	uted d ansit	Examiner	Sequentially list conditions, any, leading to minipolate cause. Enter Underlying Cause (Disease or injury that initiated events		warte or ;								
,092	ate be executed hysicien and the burial-transit	i Exa	resulting in death) Last	Due to (or as a consequence	uence of):								
6876	icate b physic s the b	dlcai		i. 2									
Box (h certif ending use a	In/Me	23b. was decedent pregnant	3c. If yes, outcome of pregna		lEctopic pr	nananav			23d. Da	ate of delivery		
o.	that the death certifica led by the attending ph detached for use as th	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of di 9☐ Unknown		Other (sp				M	onth Da	y Year	
<u>α</u>	res that igned by be deta	by Ph	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying c	ause given in F	Part I.	23e. Did to	obacco use con	co use contribute to the cause of death		
ord	w require been si should l	eted	Hypertension							Yes 2 No 3 Probably 4 Unknow			
Vital Records,	E S C	Completed	Encephalopathy						24a. Was autop perfo 1 □ Yes	med?			
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:			1	Place of Deat	th (Check only o				
o to	Phys	5	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o			Nursing Ho	ome 5 ☐ Resident		B 6 ☐ Other (Specify)		
ion	Attending r death. ector: Alter by the fune	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	of 28c. Injury at 28d. □ 28d. □ 28d. □ 28d. □ 2 □ No				as Booshoo non injury occurred			
Division of	al or Atto s eftar de d Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory	, office		28f. Location (S City or Tox		ber or Rural R	oute Number,	
	To the Hospitel or Attending Physician: The within 24 hours elter death. To the Funeral Director: Attenthis certificate his completaly filled in by the funeral director, page	Medicai (29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigation,	at the time, da , in my opinion	te and place, , death occur	and due to the red at the time,	cause(s) and m date and place,	anner as state , and due to th	ed. e cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2 0			. License num	-	1	29d. Date signe	ed (Month, De)	y, Year)	
2	+1		I Shera My)5-9	55	6	1118	107		
-	' (30. Name and address of person wholes Humera Mujahid				Cheve	rlv Ma	rvland	20785			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa			_ CLICVE	y 1°101		_20100_			
	Registi	ar	MOV 1 2 2009 /	Grand P B A	BRUKE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State of Maryl	,			l Mental Hyg	iene			
			- State Registrar		Ce	rtificate of	Death		eg. No. 2	9	38240	
Н	Physici	an	1. Decedent's Name (First, Middle,	,	Date of Deat Month	Dav	Day Year 3. Time of					
	/Medic	al	Lena	R.	Meade	1 # 60 T		Novembe		3:24 рм		
	Examin	er	4a. Facility Name (If not institution,) Ft. Washingtor			Ft. Was			4c. County of Death Prince Georges			
	Funeral Director		5. Social Security Number 231–46–1862	1□M 2F¥F	yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year)	9. Birthpla Counti Virqi		
	pu ,		Usual Residence of Decedent									
	aryla show	<u>_</u>	10a. State 10b. County	100	: City, Town or Lo Washind					10	od. Inside City Limits 1 🖫Yes 2 🗆 No	
	the M 28a-f otifie	Director	10e. Street and Number		wasiiiiig	10f. Zip Code		1	0g. Citizen of W	What Count		
	with with the r		2644 Birney P	ace. SE			020	'	U.S.A		. y :	
	ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)		e - America		
9	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a or 28a-f show marked other than "natural".		1 Never Married 2 Marrie	If Yes, Give		1 Yes, specify Cur		eno Hican, etc.)		k, White, e	_	
Ö	hours tural", al Exa	ed by	3 Note of the state of the sta	Year or Dates:		dent's Usual Occu						
7	within 72 ene. than "nat he Medica	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	kind of work done DO NOT use retire	e during most of weed)	vorking	16b. Kind of Bu	siriess/indi	ustry	
212	d with giene. rr thar	mo	Elementary/Secondary (0-12) 8th	College (1-4or 5+)	Но	ousekeepi	ng		D.C.	GOVE	ernment	
D	e file al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, La		1		1	lame (First, Middle, I			_	
<u>yla</u>	should be filed vand Mental Hygie s marked other i umatic event, the	일	Ollie		berts		Delma			berts		
E	d 2 g		19a. Informant's Name/Relationship Lenora Spencer -	* * * * * * * * * * * * * * * * * * * *		-		Rural Route Number	-			
re,	s 1 and 2 f Health tem 27 other tra		20a. Method of Disposition		Db. Place of Dispo	osition (Name of	1	-	20c. Location -			
E	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		t. Linco	matory or other pla oln cemet	ery 11-	-13-2009 E	3rentwoo	od, Ma	aryland	
	permit. Departm Importa any inju		21 Funature of Funeral Service Li					onald Tayl				
<u> </u>	8 3 E 5 8		Homalal	COOL	_ 10)583 Midd	lleport 1	Lane, Whit	e Plair	ns, Ma	aryland	
П			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the only one cause on each line.	death. Do not en	ter the mode of dy	ing, such as card	liac or respiratory arr	est,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Acut	he le	peretur	7 72	ilure				
	/Medical Examiner		(Due to (or as a cor	nsequence of):	- K	el mone	ilux	le ale	,		
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	isequence of).	(1100		J				
	cate be executed physician and the burial-transit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
8760,	be execian a	E	resulting in death) Last	Due to (or as a cor	nsequence of):							
387	icate l physi	dical		d								
X	leath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pr					23d. Dat	te of delive	rv	
. Box	death e atter	Physician/M	in the past 12 months?	1□Live birth 2□ 4□Pregnant at time		□Ectopic pregnand □ Other <i>(specify)</i> _	су				Day Year	
P.O.	at the by th	hys	9 ☐ Unknown	9□Unknown								
	The law requires that the death certifit ate has been signed by the attending page 2 should be detached for use as	þ	Part II, Other significant condition	s contributing to death but not	t resulting in the u	ınderlying cause gi	iven in Part I.		Did tobacco use contribute to the cause of death?			
oro	w require been signature should b	ted	, , , , , , , , ,				-	- 1 1 1	es 2 🔼 No	3 Proba	ably 4 □Unknown	
Records,	has by	Completed						– 24a. Was a	n 24b. V	Were autop prior to con death?	osy findings available npletion of cause of	
_	n: Th ficate or, pag		25. Was case referred to medical						24 No 1	1 □ Yes	2 ⊠ №	
5	Physician: The la rr this certificate has ral director, page 2	o Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3□ DOA Ot	hor:	Death <i>(Check only on</i>		or (Cassin	A.	
0	g Phy ter this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o			28d. Describe h				
io	Attending Physician: r death. ector: After this certifice by the funeral director. I	atio	Natural 5 Pending investiga	tion		Yes 2□No						
Division or	or Atterderinecte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		At home, farm, st pecify)	reet, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	er or Rural	Route Number,	
	pital c		29a. Certifying	Physician: To the heat of my	/ knowledge des	th cooursed at the	time data and -1	and and districts the	nauca(a) d		nto d	
	To the Hospital or Attending Ph within Z Hours after death To the Funeral Director. After th completely filled in by the funeral	Medical	(Check only one)	Physician: To the best of my xaminer: On the basis of exa and manner stated.	mination and/or in	nvestigation, in my	opinion, death o	ccurred at the time, o	date and place,	and due to	the cause(s)	
	To the within To the	Me	29b. Signature and title of certifier			29c. Licen	se number	2	29d. Date signe	d (Month, l	Day, Year)	
6			1 Colo	- de 1		D	4295	5	11/	09	12009	
0	13		30. Name and address of person w	1 1 1	/	, Print)	Ff	1.50	4.	11	1. 2009 1. 20744	
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7	Sta	ite	31. Date filed (Month Day, Year)	32. Registrar's	agriagire .	•						

			For State		State o	f Mary		partmer e <i>rtificat</i>			and M	lental Hy			09	38241
			Registrar 1. Decedent's Name	e (First Middle I	ast)			еппсат	e or L	<i>Jeain</i>		2. Date of De	Reg. N	10.20	0)	
	Physicia Medic				F. Nicho	1son						Month Novemb		4, 20	Year 09	3. Time of Death 2:02 P.M
	Examin	er	4a. Facility Name (if	, •		nber)				Location	of Death		- 1	c. County		
			Suburbar 5. Social Security N		al .Sex	7 Ane (In	yrs. last birthda		ethes		r 24 Hrs.	8. Date of Bir		Montg		lace (State or Foreign
	Funeral Director		239-07-5	992	13KDXM 2 □ F	1. Age (iii	94 Yrs	Months		Hours	Min.	4/1/19	15 Year))	Nort	n Carolina
	nd how at	ř	Usual Residence of 10a. State	Decedent 10b. County		100	c. City, Town or	Location							1	0d. Inside City Limits
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	or 28	تَّا	10e. Street and Nur				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zij	p Code			Т		Citizen of W		try?
	e flied within 72 hours after death with the Maryland the Hygiene. Hygiene, and the han "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	842 De	lafield	Place,	N.W.				20	011			U.S.A	•	
	death item		11. Marital Status		12. Was Dece Armed Fo	rces?		3. Was Dece	dent of Hi	spanic Or n, Mexica	rigin? (Spe in, Puerto	cify Yes or No- Rican, etc.)			- America	
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5	hours natura ical E	lete		15. Decedent'		ites.	16a. De	cedent's Usu	af Occupa	ation			16b.	Kind of Bu	siness Inc	lustry
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Š	nould not Me s mar		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. M	ailina Addres	s (Street a	and Numb	er or Rura	l Route Numbe	er. Citv o	or Town, St	ate. Zip C	code)
			Francene	Shelto	n (Daugh	ter)	- 1	-				rden, M			207	
2	of He fitem		20a. Method of Disp		☐ Removal from	State	0b. Place of Di	rematory or o	other place	e)		Date	20c.	Location -	City or To	wn, State
oromitle oromitle	: Pag tment tant: jury o			5 Other (Sp		F	t. Line					2/2009				Maryland
. a	permit. Page 1 a Department of H Important: If ite any injury or otl		21. Signature of Fu	neral Service Lic	ensee	097	7					rshall' W. Wash				me, Inc. 20011
ξ [23a. Fart 1. Enter t	the disease, or co		aused the	death. Do not	enter the mod	de of dying	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between
2	Physician	Ø 9	Immediate Cause ((Final			ve Hear	t Fail	lure						16	Onset and Death weeks
0	Medical Examiner		resulting in death)	4			sequence of):									
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0	ited 1 ansit	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or	rlying linjury	54010	o. uo u oo,	icoquorito ory.									
0	Attending Physician: The law requires that the death certificate be executed redesh. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	EX	that initiated event resulting in death)	s Last	Due to (or as a cor	sequence of):									
7 9	ate be hysici	dical			d											
1/	ertifica ding p	/Me	IF FEMALE:		23c. If yes, out	come of pr	egnancy									
>	attend for us	cian	23b. Was decedent in the past 12	months?	1 🗌 Live		Fetal death	B Ctopic Control Contr		у			- 6	23d. Date Mon	e of delive ith	ery Day Year
	the de by the ached	hysi	1 Yes 2 9 Unknown		9 🗌 Unkr											
NOS	s that gned k	by P	Part II. Other signif		s contributing to de	eath but no	ot resulting in th	e underlying	cause giv	en in Part	:1.	1				e cause of death?
9 5	equires sen siç ould t	ted	Dementi	.a								1 🗆	Yes 2	2 🗆 No	3 🗌 Prob	abiy 4 🖺 Unknown
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	r: The icate r, pag	CO	25. Was case referre	ad to madical	T							perfo	2 1	No 1	Yes	2 🔼 No
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OHN	endin sath. or: Aft	fica	12 Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending Investiga	tion	, Day, 160	ar) Irijut	M	work	? Yes 2 □] No					
JOH H	or Att after da Directe in by t	Certificate:	4 Homicide	6 U Could no determin	28e. Place	of Injury - A	At home, farm, ec <i>ify)</i>	street, factor	y, office			28f. Location (S City or Tow			r or Rural	Route Number,
_	spital nours neral l		29a. Certifier 1	K Certifying P	hysicían: To the b	est of my k	nowledge, dea	th occured at	the time.	date and	place, an	d due to the ca	use(s) a	and manner	r as state	d.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 only one) 3	☐ Medical Exa ☐ Certifying N	miner: On the bas lurse Practioner:	is of examin	nation and/or in	estigation, in	my opinio	n, death o	ccurred at	the time, date a	and plac	ce, and due	to the cau	ise(s) and manner stated.
_	To 1 To 1		29b. Signature and	title of certifier	ti			290	D378					ate signed ember		**
	04		30. Name and addre	ess of person wh	o completed caus	e of death	(Item 23a) (Typ	e, Print)						_		
<u>_</u>	12		Amit Raj	vanshi,	M.D. 12				ne #	409	Rock	ville,	Mar	y1and	20	852
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DHMH 17 Rev 7/2009

38242 State of Maryland / Department of Health and Mental Hygien 19 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 ar 0830 AM 16 **Physician** Jon Leonard Owen /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number)
Harford Memorial Hospital 4b. City, Town, or Location of Death **Examiner** Havre de Grace Harford 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/30/1941 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1∭ M 2□ F 217-36-4762 67 Yrs. Director Usuel Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10a. State 10b. County worle r then "naturel", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 X Yes 2 □ No Harford Havre de Grace Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 410 North Stokes Street 21078 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 1964-67 Year or Dates: 1964-67 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Marned Specity: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education al Hygiene. Colfege (1-4or 5+) Elementary/Secondary (0-12) Painter Painting permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: If Item 27 is marked other ti
eny injury or other traumatic event, IIIA
DDCE. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edna Johnson Paris Owen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth H. Olivas (Companion) P.O.Box 728 Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/19/2009 West Chester Pennsylvania R.A. Ferris & Co. Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) 48 Hours Physician FILLOMUSKI /Medical Due to (or as a consequence of). Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) Examiner burial-transit resulting in death) Last Due to (or as a consequence of): ending physiclan a use as the burial. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □Unknown Pharrager ANCER 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2000 1 Yes 25. Was case referred to medical 26. Place of Death Check only one Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation spital or Attendi nours after death. nerel Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di completely filled in Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11-17-2009 00056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Haure de Grace, Mo 21078 S. UNION BIRNDAUM, MD 501

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar		State of r	viaryiai	Cei	artment of t	neaim a Death	ind Mental Hy	/gien Reg. N	200	9	38243
	Physicia Medic		1. Decedent's Name (First, Mid Karlis Jan		st)					2. Date of D	eath	ຯ,2009≈		3. Time of Death 2:30рм
		4a. Facility Name (if not institution, give street and number) 1331 Center Street						4b. City, Town, o		Death	4c. County of Dea			nde1
	Funeral Director		5. Social Security Number 217–38–9955	6. S	ex X M 2 □ F		last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bi Min. (Month, D Dec 4	rth ay, Year 193	9.	Birthpl Count	ace (State or Foreign
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. Cour MD Anne		undel		ty, Town or Lo	cation		•			_	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the Miss 23a or 28	Funeral Director	10e. Street and Number			1 00	ienton	10f. Zip Code	113		10g. 0	Ditizen of What		A
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medic at Examiner must be notified at once.	ted by Fur	11. Marital Status 1 Never Married 2 □ N 3 □ Widowed 4 □ Divorce		12. Was Deceden Armed Forces 1XXYes 2 [If Yes, Give Year or Dates.	? No		Was Decedent of H If Yes, specify Cuba 1 Yes 2 XNo		n? (Specify Yes or No Puerto Rican, etc.)	en.	14. Race - Al Black, W Specify: W		tc.
21215-0036	within 72 hou giene. er than "nat i, the Medica	Completed by	15. Dece (Specify only his Elementary/Seconday (0-12 12	hest gr		r 5+)	(Give life. D	dent's Usual Occup kind of work done O NOT use retired) ity Work	duning most o	of working	16b.	Kind of Busine Wareh		,
Maryland	d be filed v Mental Hyg arked other atic event,	To Be	17. Father's Name (First, Middle Eduards Ozoli							's Name (First, Middle Bergmanis		n Sumame)		
	nd 2 shoul ealth and t n 27 is ma		19a. Informant's Name/Relation Andy Baltins	nship (7	ype, Print) Friend					or Rural Route Numb 11s, Md 21			Zip Ci	ode)
Baltimore,	t. Page 1 au tment of He tant: If iter ijury or oth		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	r (Speci	fy)	te	cemetery, crer	osition (Name of matory or other place n Cemete		Date 1/12/2009	l .	Location - City en Burn		
Bal	permit Depar Impor any in		21. Signature of Fundral Service	e Licen:	7/		22 H	2. Name and Addre	ss of Facility Funera	1 Home P.A	A. 8	51 Anna ambrill	go,	is 21854
	Physician/ Medical Examiner		23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or com	plications that causone cause on each line. a. Due to (or a	ne.	any	er the mode of dyin	ng, such as ca	ardiac or respiratory a	trest,	<u>`</u>		Approximate Interval Between Onset and Death
	ifficate be executed og physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	{	b. Due to (or a								ļ	
09/	physicia the bur	edical		·	d								+	
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live Birtl 4 ☐ Pregnant 9 ☐ Unknown	al death 3	Ectopic pregnand Other (specify)	су			23d. Date of Month		ry Day Year		
ds, P.O.	quires that then signed by	by	23e. Did tobacco u								use contribute to the cause of death			
Division of Vital Records,	Physician: The law rec rthis certificate has be rral director, page 2 sho	Completed									psy ormed?	death	?	sy findings available inpletion of cause of
Vital	ysician is certifi director	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	al	Hospital:	atient 2	ER/Outpatier	Oth	ar:	(Check only one) sing Home 5 🗗 Res	idence	6 ☐ Other (Sc	ecify)	-
on of	ending Ph eath. or: After th he funeral	Certificate:		stigatio	28a. Date of in (Month, L	jury	28b. Time of injury	28c. Injur	y at	28d. Describe				
Divisi	ital or Att urs after de ral Directo			ermined	building,	etc. (Specif	5/)	reet, factory, office 28f. Location (Street and Number or City or Town, State)						
	the Hosp thin 24 hou the Fune mpleted fi	Medical	(Check 2 L Medic	ing Nur	iner: On the basis of	examination	on and/or inves	tigation, in my opini death occurred at th	on, death occ ne time, date a	lace, and due to the courred at the time, date and place, and due to t	and place he cause	ce, and due to the e(s) and manner	ne cau	se(s) and manner stated. ted.
0	5 ≱ 5 ⊗		June	*	The same				3 S	7		ate signed (Mo		
C.	4 41		30: Name and address of personal James E					_{Print)} Highway (Glen B	urnie,MD	210	61		
	Stat Registra		31. Date filed (Month, Day, Year		20 Deal	Augula Ciana	Acres	park						

09-08930 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Steven Orndorff State of Maryland / Department of Health and Mental Hygiene 2009 38244 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1, Decedent's Name (First, Middle,Last) Physician/ Month November 17, 2009 0906 hrs **Medical Examiner** Steven Michael 4 1 Orndorff 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 5316 Sharpsburg Pike Sharpsburg Washington 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6 Sex Foreign Country Maryland Months Days Hours Min Director 218-82-9350 June 23, 1962 1X M 2 47 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State Sharpsburg 1 X Yes 2 No Maryland Washington permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho Director 10g. Citizen of What Country 10e. Street and Number 10f, Zip Code 5316 Sharpsburg Pike 21782 U.S.A. Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 Never Married 2 Married 2 X No Yes White 4 X Divorced Yes 2 X No specify: 3 Widowed If Yes. Give Year Specify. à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Meat Cutter Grocery 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Bruce Allen Orndorff Peggy Lorraine Stottlemyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is n 2950 Roop Road Steven H. Aberts / Executor Taneytown, Maryland 20a. Method of Disposition

1 Burial 2 A Cremation 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Stauffer Crematory 11-19-2009 Frederick, Maryland Other Specify. Donation 5 ral Service Opense 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 hat ca sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval nter the disease, or complications Physician Between Onset and failure. List only one cause on each line /Medical Death a Mixed irug (propoxphene, alprazolam and quetiapine) caminer or condition resulting in death) Due to (or as a consequence of): and alcohol intoxication Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,28a-f,permE, g899 1/28/10 TT X UNPENDED physician the burial -Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Yea Live birth Day Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28c. Injury at Work? 28d Describe how injury occurred subject ingested drugs and After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Natural Yes 2X No Director: d in by the f Pending within 24 hours after death. Fd 11/17/09 FD 0859 hrs alcoho1 2 X Accident Investigation $^{28f.}$ Location (Street and Number or Rural Route Number, City or Town, State) $5316 \atop Sharpsburg$, MD $^{28f.}$ 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide To the Funeral I filled determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. November 18, 2009 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Phylys r) Registrar

38245 Amend Item Z per dr., g898, 12/14/09dhb Certificate of Death Reg, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 3. Time of Death Month Day 14, 1009 Physician 11:10 AM Ruth Peterson Laura Dawn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NMS Health Care Of Hagerstown Hagerstown Washington 8. Date of Birth
(Month, Day, Year)
JULY 19,1921 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F Maryland 578-20-2016 88 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 XNo Director Marvland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 U.S.A. 14014 Marsh Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be С. Harry Mvers Ina Belle ٩ Spraque 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George S. Sunday 193 Durham Drive, Chambersburg, Pa. 17202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Wildwood Cemeterv 11-19-09 4 ☐ Donation 5 ☐ Other (Specify) Bartow, Florida ^{22. Name and Address of Facility}
Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, Hagerstown, Md. 21740 21. Signature of Funeral Service Lice K hoel Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OPD Physician CRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CONGESTIVE HEART FALLICE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties of the properties of the second secon 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a, Was an Jas autops, performed: 20100 page certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending To the nosposses within 24 hours af er death.

To the Funeral Director Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11-14-09

WH 3

State Registrar 31. Date filed (Month, Day, Year) NOV 1 7 2009

Michelle

30. Name and address of person who complete (quuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

Leneur J. Jak

Hajesburn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 105/89 10:40 a^M James Wesley Porter Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Manor Care Nursing Home Largo Prince George 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03/18/36 9. Birthplace (State or Foreign Country) Georgia if Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 🙀 M 2 🗆 F Days Hours Director Yrs 577-50-0923 73 Usual Residence of Decedent 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Capitol Heights 1 X Yes 2 No Maryland Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20743 6211 Baltic Street death \ 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No 72 hours after ☐ Yes Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: and Mental Hygiene. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Painter Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic evo ပ Willie Mae Jenkins Benny Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Porter/ Daughter 5707 Addison Road Seat Pleasant, Md. 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/09 Landover, Maryland Stewart Funeral Home, Inc. 21. Signal or of Funeral Service Ligenside 22. Name and Address of Facility 4001 Benning Rd. NE Washington, DC 20019 23a. Part T. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, Examine cause. Enter Underlying Due to (or se a nonecquence or) and I-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No. Yes ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? by Lung Cancer 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🕱 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending death. nours after death neral Director: A I filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours e Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number 11-09-2009 D 51520

DHMH 17 Rev 7/2009

State Registrar # 310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahram Pishdad, MD 1328 Southern Ave. SE

31. Date filed (Month, Day, Year) NOV 1 2 2009

State of Maryland / Department of Health and Mental Hygiene 38247 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Ann Marie Pirrone 3:13 A M November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🖾 F Yrs 579-56-3646 67 Director September 3,1942 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Examiner must be coulded at Director 1 Tx Yes 2 □ No Prince George's Maryland | Riverdale 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 5610 Patterson Street 20737 USA death v Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ,o 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify. ð Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Water Proofing Co. Marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lininy or other traumatic event 2008. Be Ethel Agnes Cropp Michael Joseph Pirrone 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Williams Smith / Daughter 7833 Riverdale Road, #303, New Carrollton, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery | 11/13/2009 | Brentwood, Maryland 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility 4739 Baltimore Avenue lance Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Acute Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 🖾 No signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 X No of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) e Hospital or Attending P 24 hours after death. e Funeral Director: After t letely filled in by the funera 28b. Time of 28d. Describe how injury occurred After Injury at Work? Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Dires 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title, of certifia 29d. Date signed (Month, Day, Year) 29c. License number H64588 11/9/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashish Kishore Tolia, 1500 Forest Glenn Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) NOV 1 2 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38248 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 Month 09^{Day} Physician/ Roy Nelson Pea 2009 8:34 a^M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Doctors Community Hospital PG Lanham If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 251-42-3022 03-31-1928 1 XM 2 □ F 81 Months Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD PG Capitol Heights 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 6614 Wilburn Dr. 20743 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1951-Black, White, etc. δ 1 Never Married 2 Married s filed within 72 hours after tal Hygiene. ed other than "natural", o If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 1953 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Dept. Of Agriculture Elementary/Seconday (0-12) College (1-4 or 5+) Research Analyst other traumatic event, Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other than 10 permits any injury or other than 10 permits any injury or other than 10 permits any injury or other than 10 permits any injury or other than 10 permits any injury or other than 10 permits any injury or other than 10 permits and 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Emanuel Pea Mamie Lou Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6614 Wilburn Dr. Capitol Heights, MD 20743 Juanita Pea/ Wife 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD Veterans Cemetery 11-16-09 Cheltenham, MD 4 Donation 5 Other (Specify) 2. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II FH 0583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Aspiration Pneumonia Medical Due to (or as a consequence of Examiner Hyponatremia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin and I-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? performed' ☐ Yes 2 X No 1 Yes 2X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2X No 1 🗌 Yes ဂ္ဂ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending nours after death. 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2
To the I comple

3+1 State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 7/2009 29b. Signature and title

Azeez Abiodun M.D.

NOV 1 2 2009

8118 Good Luck Rd. Lanham, MD 20706

MO

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D62810

29d. Date signed (Month, Day, Year)

11-10-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Florence W. Payne 2009 /Medical 4c. County of Deaf 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Year) Months Days Min. 1 □ M 2 🔀 F 216-44-2980 100 Director March 28, 1909 Wisconsin Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exyminar must be rediffed at Director 1 XYes 2 No Prince George's University Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 USA Completed by Funeral 6505 41st. Avenue 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Clerical 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any liury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Richard A. Wendorff Martha G. Kleinbauer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Payne / Son 9000 Brookridge Drive, Upper Marlboro, MD 20772 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 11/14/2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue elles 4 Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Asystole Cardiac Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Hyperkalemia and Due to (or as a consequence of) physician Box 68760 Physician/Medical Hypoxic Brain Injury After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as: IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ Metabolic Acidosis 1 Tyes 2 No 3 Probably 4 N Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Renal Insufficiency 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 2 🛛 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea. "al Director: After 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 29a, Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, NOV 1 2 2009

30. Name and address of berson who completed cause

Year)

of death (Item 23a) (Type, Print

29c. License number

29d. Date signed (Month, Day, Year)

Avenue

7600 Carroll

Takoma Park, MD 20912

			1-For Amend Item 29d per dr., g89	partment of Health and Nortificate of Dooth	Mental Hygie	ene	00050	
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg.	. No. 2 1 1 9	3 8 2 5 U	
	Physicia		Marie Imogene Price		NO VEM SEN	Day Year	2:43 PM	
-	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	<u>'</u>	4c. County of Death		
			WASHINTON CONTY HOSPITAL	HAUGHSTOUN		WASHING		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd:	Months Days Hours Min	8. Date of Birth (Month, Day, Ye.	ear) Coun	olace (State or Foreign try) sylvania	
			Usual Residence of Decedent		-(25/	1-1		
	ıryland a-f she ied at	Director	10a. State 10b. County 10c. City, Town o			1	0d. Inside City Limits 1 Yes 2 No	
	he Ma or 28a or potif		MD Washington Hagers 10e. Street and Number	TOWN 10f. Zip Code	100	a. Citizen of What Coun		
	with t	Funeral	410 1/2 Guilford Ave.	21740		U.S.A.		
	death item		Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 		14. Race - Americ Black, White, 6		
336	s after al", or Exami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates,	1 ☐ Yes 2 🕅 No Specify:		Specify: Whit		
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d 2	led with Hygie other other ent, tl	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	Textile		
Maryland 21215-0036	d be fil dental rrked tic ev	욘	Eugene Leap	Amelia				
lan	shoulk and h is ma			lailing Address (Street and Number or Rura				
e,	and 2 Health em 27 ther to) 1/2 Guilford Ave.				
nor	age 1 ent of nt: If it y or o		1 Burial 2 Cremation 3 Removal from State cemetery,	crematory or other place) aven Cemetery 11/1		c. Location - City or To Hagerstown		
altimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important if fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee			Funeral Cl		
Ω	e a m e e		I S. Merk Sugge	1601 Pennsylvania			21742	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause or leach line.	Failure / Legal Tollure / Legal Tollure / Legal	1		Approximate Interval Between Onset and Death	
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and a	Examiner	L	Sequentially list conditions, b. Chric obstant					
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P.O. Box 687	the a	Physician/Me	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown	5 Other (specify)		WOILT	Day Year	
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o	ng Pn ffer th Ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury injury	e of 28c. Injury at	28d. Describe how in			
sion	or Attending after death. Director: After I in by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	207 1 11 12		B 4 M 4	
Division of Vital Records,	al or A s after I Direct d in by		4 Homicide determined building, etc. (Specify)	street, factory, office	City or Town, St	treet and Number or Rural Route Number, n, State)		
_ [To the hospital of Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, der (Check 2 Medical Examiner: On the basis of examination and/or in	th occured at the time, date and place, an	d due to the cause(s	s) and manner as state	d.	
-	ithin 2 o the F		only one) 3 Certifying Nurse Practioner: To the best of my knowledge. 29b. Signature and title of certifier	ge, death occurred at the time, date and place 29c. License number	e, and due to the cau	use(s) and manner as sta	ated.	
	-≯Fŏ			056023		11/13	72009	
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e Print)		1120	// -	
	Stat	P .	11. Date filed (Month, Day, Year) Registrar's Signature	cs, 1138 of al ct, 1+a	agentank	M) (1)	10	
	Registra		DEC 0 1 2009 Rema S. A.	ald				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Edward Lynn Ream 2009 4:30 P.M November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 12413 Madeley Lane Rowie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 🔀 M 2 🗆 F Director 220-32-4289 74 1935 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Prince George's Bowie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20715 12413 Madeley Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Year or Dates. 1957-59 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AT&T 12 Telephone Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma Pear1 Hoye Gilbert Harland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Admiral Drive, #303, Annapolis, Maryland 21401 Amy E. M. Oxendine/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/09 Crownsville, Maryland Maryland Veterans 22. Name and Address of Facility Robert E. Evans Funeral Home, 21. Signature of Funeral Service Licensee ADL 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myscardia Physician/ nobable disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

DHMH 17 Rev 7/2009

сотретер

Medical

29a. Certifier

29b. Signature and title of certifie

4175

31. Date filed (Month, Day, Year)

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determined

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CA

32. Rehistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HMSOL

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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28389

Jeffery T

Hoeck

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month, Day, Year)

11-5-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 38252 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:25 A M Gladys Saha Roell Medical November 2009 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince Georges Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Months Hours Min. October 15,1923 Country) 578-32-5407 86 Director IL Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10450 Lottsford Road 20721 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Saha May Rejsek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra D. Robertson/ Daughter 1750 Ullswater Place Crofton, MD 21114 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otf 20c. Location - City or Town, State National Memorial Park 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/9/2009 Falls Church, VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ Meumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner chronic obstructive 4 cars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami to month attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 0 Years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires the hours after death.
 Funeral Director: After this certificate has been sign. osteo povosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) Hospital: Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 1 ☐ Yes 2 🛣 No ဂ္ 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation completed filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the only one Cartifying Nurse Practioner. To the best of my knowledge death d at the time, date and plans, and due to the c

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

29b. Signa

re and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print)

0042049

upper Maulboro

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/9/2009 Physician/ 12:30pm Elizabeth A. Rosenberger Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7896 Pavilion Dr. Severn Anne Arundel . Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) CA 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 M 250F Hours 1/19/1929 Director 80 Yrs 113-24-1355 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2xxNo MD Anne Arundel Severn 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7896 Pavilion Dr. 21144 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force þ Black, White, etc. 1 Never Married XX Married 1 ☐ Yes 2XX No If Yes, Give 1 ☐ Yes 2XX No Specify: White Specify. 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or and injury o 18. Mother's Name (First, Middle, Maiden Surname) Albert Francis Hopstein Elizabeth Lillian Robaire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Rosenberger/Husband 7896 Pavilion Dr. Severn, MD 21144 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial XX Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) 11/11/2009 Glen Burnie, Md Signature of Faneral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Da 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) bro vasc Cere Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physician and thed for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Year Pregnant at time of death 5 Other (specify) Day 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Nonknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 2 🔲 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No

Box 68760 P.O. Records, Division of Vital the funeral director.

Maryland 21215-0036

Baltimore,

To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this contiffer s after death.
al Director: After th completed filled in by

Accident

Suicide

4 Homicide

only one

31. Date filed (Month, Day, Year)

29a. Certifier (Check

State Registrar

Medical

title of certifie

Investigation

determined

6 Could not be

50725

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Veterans thun M. Mersv. U. M. 2/108

City or Town, Statel

28f. Location (Street and Number or Rural Route Number,

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		1	For State Registrar	ate of Maryland / Dep: Ce	ertificate of E		rental Hygi	ene eg. No 20	09	38254
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	Medic Examin	ai .	Goldie Kenesey 4a. Facility Name (if not institution, give street	Rowell and number)	4b. City, Town, or	Location of Death	November	4c. Count		0:33 AW
	LAdiiiii	GI	1017 Old Bay Ridge		Annap	olis		Anne	Arur	ndel
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthday) 2 XF 9 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Bay, 0271,97)	19 16	g. Birthp Coun Of	place (State or Foreign tnd) 110
	nd show at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le	ocation				1	0d. Inside City Limits
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imo	Page nent o ant: If ant: If ury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ Remarks 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Atlanti	ematory or other place ic Cremato	ry 11/10	0/09	Glen Bu	ırnie	,MD
Balt	permit. Departimont amy inj		21. Signature of Funeral Service Licenses	i F	22. Name and Addres Hardesty F	ss of Facility Juneral Ho	ome P.A.	12 Ric Annapo	dgely ofis	MD 21041
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	cate be executed physician and the burial-transit	Exal	that initiated events c resulting in death) Last	HYPERTENSION Due to (or as a consequence of):	<u> </u>		····			
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	þ	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	-1		he cause of death?
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	To the within To the comp	2	29b. Signature and title of certifier		29c. Licens		2	9d. Date sign		
	ŀ		30. Name and address of person who compl		3	000139		11/10	109	
('AHA		Carol A. Pressey	3168 Brave	ston St.	*290 4	edgeun	ter r	10 E	21037
Ì	Sta Registr		31. Date filed (Month, Day, Year) NOV 12 200	32. Registrar's Signature	back		7			

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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			For State	State of Marylar		artment of H <i>tificate of L</i>		l Mental Hy	/giene		
			Registrar 1. Decedent's Name (First, Middle,	, Last)	06/	tillcate of L	Jean	2. Date of De		009	3.7 ime or peats 2
	Physicia Medic		Virginia	May Rogers				North	ber Day 15	2009	9:30 M
	Examin	er	4a. Facility Name (if not institution,			4b. City, Town, or		ath		nty of Death	
	Funeral	-	Washington Cou	unty Hospital 6. Sex 7. Age (In yrs.	last birthday)	Hager	stown I If Under 24 H	rs. 8. Date of Bi		shing	place (State or Foreign
	Director		217-32-5428 Usual Residence of Decedent	1 □ M 2 X □ F 95	Yrs.	Months Days	Hours Mi	Januar	ÿ ² 24,19	14 Cay	aryland
	land show	tor	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Mary 28a-1 notifie	Director		ington	Hagers						1 ¥ Yes 2 □ No
	ith the		10e. Street and Number 351 Key Avenue	2		10f. Zip Code			10g. Citizen o		ntry?
	eath w	Funeral	11. Marital Status	12. Was Decedent Ever in U.		21740 Vas Decedent of H	ispanic Origin? (S.A.	can Indian
98	fter d ", or if amine	þ	1 Never Married 2 Marri	Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give	- 1	f Yes, specify Cuba ☐ Yes 2 ☐ X No		erto Rican, etc.)	В	lack, White,	etc.
Š	ours a	eted	3 X Widowed 4 □ Divorced	Year or Dates.						ify: Whi	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed		College (1-4 or 5+)	(Give I	lent's Usual Occup kind of work done o O NOT use retired) memaker	ation furing most of w	orking	16b. Kind of	Home	dustry
Maryland	d be filed within 7 Mental Hygiene. Wed other than Itic event, the M	To Be	17. Father's Name (First, Middle, La Crist Pr	ast) Yeston Mertz	Sr.		18. Mother's N	lame (First, Middle	_	me)	
Mary	2 should Ith and M 27 is ma r trauma		19a. Informant's Name/Relationshi Betty Jane Te			ng Address (Street a	and Number or F	Rural Route Numb	er, City or Town	, State, Zip	
Je,	ge 1 and 2 s it of Health If item 27 i or other tra		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place		Date	20c. Location		
ij	Page 1 ment of tant: If it tury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			n Cemete		-19-09	Hagers	stown,	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	7	² A 4	Name and Address ndrew K. O East Ar	Coffmar ntietam	Funeral Street.			Md. 21740
	Physician/ Medical		23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	complications that caused the deal only one cause on each line. a. Due to (or as a consequence)	th. Do not ente	er the mode of dyin	g, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	b. ————————————————————————————————————	0						
	ecuted and Il-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseq							
09289	e)	_	resulting in death) Last	d.			<u> </u>				
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Of the Funeral Director, 24th. Completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome of pregn: 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnanc	У			Date of deliv	ery Day Year
P.O.	that the ned by a deta		Part II. Other significant condition	ons contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to tl	ne cause of death?
ds,	requires the been signed should be	ted	Hypertension	, Itspination	pne	umpnis		_ 1 🗆	Yes 2 □ No	3 🗆 Pro	bably 4 hknown
Records,	hysician: The law re his certificate has be il director, page 2 sho	Completed by	<u> </u>						psy ormed?	o. Were auto prior to co death? 1 \(\sum \text{Yes}	psy findings available mpletion of cause of
la	cian: T ertifica ctor, p	Be	25. Was case referred to medical examiner?			26. Pla	ace of Death (Ch	1 L Yes neck only one)	2 [470]	i Li fes	2 🗆 NO
of Vital	Physic this or	은	1 Yes 2 10		ER/Outpatien		4 ☐ Nursing	Home 5 Resi	dence 6 🗆 Or	ther (Specify)
o uoi	Attending P death. ctor: After y the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigs 3 Suicide 6 Could n	gation	28b. Time of injury	28c. Injury work M 1 \square	rat ? Yes 2 □ No	28d. Describe	how injury occu	ırred	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		4 Homicide determin	ined 28e. Place of Injury - At he building, etc. (Specifi	y)			City or To	wn, State)		Route Number,
	n 24 ho n 24 ho le Fune	Medical	(Check 2 \square Medical Ex	Physician: To the best of my know xaminer: On the basis of examination Nurse Practioner: To the best of m	n and/or invest	igation, in my opinic	n, death occurre	d at the time, date.	and place, and c	tue to the ca	use(s) and manner stated
	To the within To the Com		29b. Signature and title of certifier			00-1:	and complete as as				
	_		30. Name and address of person w	who completed cause of death (Iten	n 23a) (Type, P	rint)		. •	1000	سكوا	10 ,2007
S	H-ユ		JUDINI MB	AOUATO 2	SIE	Antiet	am 31	- 1kge	Spun	, MD	
	Stat Registra		31. Date filed (Month, Day, Year)	2009 32. Jegistrar's Signa	ature.	295. Liderise D62 rint) Antret		0			

Registrar DHMH 17 Rev 7/2009

Amend #25, per ME g907 4/13/10 TT "ME g902 4/13/10 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Corsandra Ann Byrd Roberson November 7, 2009 2210 hrsw Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1952 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Hours North Carolina 57 238-96-6282 **Director** January Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 X Yes 2 □ No Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11531 Summer Oak Drive 20874 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces? 1973-Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 1985 Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Walter Reed Army Elementary/Seconday (0-12) College (1-4 or 5+) 3 Secretary years Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert McKinley Lottie Blair Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Clark Roberson (Husband) 11531 Summer Oak Drive; Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Selma Memorial Garden's Selma, North Carolina 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Sonature of Foneral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Inijury that initiated events Examine Due to (or as a consequence of): PPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last CERTIFICATION Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Live Birth 2 Live Signal Pregnant at time of death 3 ☐ Ectopic pregrie
5 ☐ Other (specify) in the past 12 months? Day Yes 2 No Unknown 9 X Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of death? After this certificate 1 Yes 2 No Yes 2 1 Vital F the Hospital or Attending Physician: eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 X Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 ☐ Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continued To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Gertifying Nurse Practioner: To the best of my knowledge dee completed cause of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** LOUISE **EDNA** ROBINSON NOV. 11 2009 1815p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FT. WASHINGTON HOSPITAL WASHINGTON PRINCE GEORGES FT. If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Hours Days 1 □ M 2 🔀 F Director 244-70-8518 89 20, 1920 NC Apr. Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County show ral", or items 23a or 28a-f show Director 1 □Yes 2KINo Dunn NC Harnet 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 710 East Granville St. 28334 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 14. Race - American Indian. 11 Marital Status Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes Give Specify: à Black 3 X Widowed 4 Divorced Year or Dates: "natural", Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 5th Cannon Foods, Inc. Factory Worker h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be fi Mental h James Wright Beulah Leake ပ္ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Hallie Wyman-Daughter 3720 Wilkinson Dr. Suitland, Md. 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages nent of permit. Pages Department of Important: If its any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-20-2009 Resthaven Cemetery Dunn, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 21. Signature of Euperal Service Licensee 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 125.5 resulting in death) /Medical Due to (or as a pasequence of): Examiner 205 Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine and that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 physician the burial Box 68760. certificate be Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Por in the past 12 months? Month Year 5 Other (specify) detached ☐Yes 2 No o 9 Unknown 9 Unknown signed by the ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy ane. nia performe certificate 1 ☐ Yes 2 ☐ No 1 No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) E No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA ٩ filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. i or Attend after death Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital c 24 hours at 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number bause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 10 10 He V31. Date filed (Month, Day, Year) State NOV 1 Registrar

(Give kind of work done during most of working life. DO NOT use retired)

16a. Decedent's Usual Occupation

Homemaker

17623

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, It. Mental a Event in the mental and the property of the property or other traumatic event, It. Mental a Event in the mental and the property of the p Baltimore, Maryland 21215-0036 permit. Page Department of Important: If any Injury or

Physician

/Medical

Director

Funeral

2

Completed

Be

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17623

Elementary/Secondary (0-12)

Isela Segovia 20a. Method of Disposition

Florentin

4 Donation

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

William Dooly, MD

31. Date filed (Month, Day, Year,

NOV 1 3 2009

15. Decedent's Education (Specify only highest grade completed)

Rosales

1 XBurial 2 ☐ Cremation 3 ☐ Removal from State

5 ☐ Other (Specify)

College (1-4or 5+)

(Daughter)

Examiner

Funeral

Director

Physician /Medical Examiner

The law requires that the death certificate be executed certificate

Division of Vital Records, P.O. Box 68760,

21. Signature of eral Service License reno 23a. Paul. Enter the discusse, or complete ons that caused the death. Do nock, or heart failure. List on, one cause on each line. mmediate Cause (Final disease or condition resulting in death) Acute Myocard Due to (or as a consequence Coronary Artes Sue to (or as a consequence of Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 X No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in <u>چ</u> Diabetes Mellitis Completed cate has page 2 s Hospital or Attending Physician: ours after death.

eral Director: After this certification by the funeral director, Illed in by the funeral director, I 25. Was case referred to medical examiner? Be Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Ou Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. 1 1X Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, fa building, etc. (Specify) determined 4 \(\text{Homicide} \) 24 hours a Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an 29a. Certifier Medical and manner stated. 29b. Signature and title of contifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Gate of Heaven 11/1	L6/2009 Silver Spring, MD
22. Name and Address of Facility F 9013 Annapolis Rd.	Rendon/Hale Funeral Home . Lanham, MD 20706
death. Do not enter the mode of dying, such as cardia	
ocardial Infarction	minutes
nsequence of):	
Artery Disease	Years
nsequence of)*	
nsequence of):	
regnancy	23d. Date of delivery
Fetal death 3 ☐ Ectopic pregnancy e of death 5 ☐ Other (specify)	Month Day Year
at resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown
	24a. Was an 24b. Were autopsy findings available
	autopsy performed? death?
	1 □Yes 2 ☑No 1 □Yes 2 □No
	ath (Check only one)
2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
28b. Time of 28c. Injury at	28d. Describe how injury occurred
ar) Injury Work? M 1⊡Yes 2⊡No	
At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
pecify)	City or Town, State)
y knowledge, death occurred at the time, date and plac amination and/or investigation, in my opinion, death occ	re, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
29c. License number	29d. Date signed,(Month, Day, Year)
M 037261	November 9 voo 9

18. Mother's Name (First, Middle, Maiden Surname)

Lindstrom Court Gaithersburg, MD 20877

Felicita

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code

Date

16b. Kind of Business/Industry

20c. Location - City or Town, State

Own Home

Rubio

State Registrar 9901 Medical Center Drive Rockville, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Дау} 04 Month ^{Year} 09 0325 Physician Anthony Ray /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Prince George Hospital Center Cheverly 9. Birthplace (State or Foreign Country)

DC If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F 07/07/54 55 Director 578-78-4609 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat mast be rediffed at 1 X Yes 2 □ No Washington Director DC the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any lipity or other traumatic event, the Medical Examiner mass resonce. United States 20019 5000 North Helen Burrough Ave N.E. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 □Yes ŽŽNo Specify ò 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Hospital Orderly 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Essie Lee Pope James Cobb ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2122 Columbia Place Landover, Md. James Cobb/ Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland Cedar Hill Cemetery 11/12/09 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Licensee 20019 Washington, DC 4001 Benning Rd. NE 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac ata **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ☑ No 1 ☐ Yes 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 2☑No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

31. Date filed (Month, Day, Year) 2 2009

FARHAD

29b. Signature and title of certifier

32. Registrar's Signature face.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMALI

Registrar

29d. Date signed (Month, Day, Year)

20058213 11/619

12150 Annapolis Rd Glenn Dale MD 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08421 State of Maryland / Department of Health and Mental Hygiene Thomas Rodgers 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 30, 2009 Thomas Rogers 1415 hrs Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Cheverly Prince Georges Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 6. Sex 5. Social Security Number **Funeral** Min. N.C Hours 239-68-8391 Months Days 12-4-1944 Director 64 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10a, State 10b. County P.G. Oxon Hill 1 Yes 2 XNo marked other than "natural", or items 23a or 28a-f show e event, the Medical Examiner must be notified at once. MD Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20745 U.S.A. 2113 Alice Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funera Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces' 1 Never Married 2 XMarried Black Yes 2 X No imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Yes 2 X No specify: Specify Yes, Give Yea Divorced 3 Widowed è 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Private 12 Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mattie Green Odell Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2113 Alice Ave. Oxon Hill MD. 20745 19a. Informant's Name/Relationship (Type, Print Joey Martinez (Son) 20b. Place of Disposition (Name of cemetery crematory or other place) Crem . 20c. Location - City or Town, State 20a. Method of Disposition Date timore, 11-16-09 Riverdale MD. Burial 2 XCremation 3 Removal from State Riverdale Park Donation 5 Other Specify 22. Name and Address of Facility Hunt Funeral 21. Signature of Funeral Service Lice 908 Kennedy St. N.W. 20011 Wash, Hunt 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical signed by the attending physician be detached for use as the burial -UNPENDED **AMENDED** The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>۾</u> Yes 2 ✔ No 3 Probably 4 Completed Division of Vital Records, 24b. Were autopsy findings available 24a, Was an 2 should certificate has been prior to completion of cause of autopsy performed? death? 2 page ✓ Yes 2 1 V Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be Other₄ examiner? Hospital: Inpatient 2 V ER/Outpatient 3 this 1 ✔ Yes No 28a. Date of Injury (Month, Day Year) Oct 30, 2009 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Driver auto fixed object collision Certification 1313 hrs Natural 1 Yes 2 V No Pending 24 hours after death. Funeral Director: Director: 2 V Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Outer loop 495 @ Baltimore Avenue, College Park, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2 To the F

31. Date filed (Month 2 2009 State Registrar

29b. Signature and title of certifie

Victor Weedn MD JD

81

32. Registrar's Signatu

Medical

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

el

Assistant Medical Examiner

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 31, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 200 ga 0755 Christopher E. Ruffin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months 1471971950 North Carolina 577-66-3660 58 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1x Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11554 February Circle 20904 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I Printer WTTG Fox Channel 5 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Leon Ruffin Sr. Floretta Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a tant; If item 27 is Debra D. Ruffin - Spouse 11330 Cherry Hill Rd #302, Beltsville, M.D. 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 11/6/2009 4 Donation 5 Other (Specify) Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signatury of Funeral Service Lice 3401 Bladensburg Rd Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) a Liver Disease Medical Due to (or as a consequence of): Examiner Hepatitis C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or imjury Cirrhosis that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ctopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No ģ Month Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Disease Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 X No 2 \square No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar (Check

29b. Signature and title of certifi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0061887

29d. Date signed (Month, Day, Year)

11/10/2009

			_ For	State of Maryland				/lental Hyg	giene	
		1	State Registrar		Cer	tificate of L	Death		Reg. No.	9.39262
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)	2				2. Date of Dea Month	Day Ye	
	/Medic		ANNCK	OYCE			t Day of Day the		er 10, 20	0,5
Tools of	Examin	er	4a. Facility Name (If not institution, give str		i	-	Location of Death re1			George's
	Funeral		Laurel Regional Ho 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Day		Birthplace (State or Foreign Country)
	Funeral Director		579 - 42 - 0533	/ 2⊠ F 77	Yrs.	Months Days	Hours Min.	Septembe:	r 4,1932 V	Virginia
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loc	eation				10d. Inside City Limits
	aryla shov	jo			ltsvil					1⊠Yes 2□No
	the M	Director	Maryland Prince Ge 10e. Street and Number	orge's De.	LCSVII	10f. Zip Code			10g. Citizen of Wha	t Country?
	3a or	Ö	11202 Cherry Hill	Road, Apt. T	3	20	0705		USA	
	hours after death with the Maryland tural", or items 23a or 28a-f show at Everning roust be routified at	Funeral		. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of H	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-	14. Race - A	American Indian, Vhite, etc.
õ	after or ite		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		□Yes 2⊠No	Specify:	, , , , , , ,	Specify:	
215-0036	hours ural",	sd by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:	16a Decer	lent's Usual Occup	ation		16b. Kind of Busin	
는 스	n 72 n	olete	15. Decedent's Educa (Specify only highest grade of	completed)	(Give	kind of work done of NOT use retired	during most of work	king		·
7.17	r withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Admin	istrativ	e Clerk		Food Ser	vices
g	al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)					•	Maiden Surname)	
<u>a</u>	ould b Ment arked aric e	은	Bernard Westley Fl	ing			Ruby Eth			
Maryland	2 shk h and r Ism raum		19a. Informant's Name/Relationship (Type			-			er, City or Town, Sta rick, MD	
e,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene, item 27 is marked other than "natural", or items 23a or 28a-f show cother traumatic event, I'n Medical Exeminer must be multilited at	l I	Michael Edward Roy 20a. Method of Disposition			sition (Name of natory or other place		Date	20c. Location - Cit	
ğ	ages ent of tt: If it y or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	moval from State I	-	an Cremato		2/2009	Alexandri	a, Virginia
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee			. Name and Addre			4739 Bal	timore Avenue
ñ	any any one		Leans At a	Ulmen	Ga	asch's Fu	nera <u>l</u> Hor	ne, P.A.		11e, MD 20781
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the death cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Chronic Obst	ructiv	e Pulmon	ary Disea	ase		Chast and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
	_xammo	in lie	Sequentially list conditions, b.	Hepatitis Due to (or se a consequ	isnes of):					
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Hypoxia						
o,	an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	ficate be executed physician and s the burial-transit	dical	d.							
	ertific ling p e as t	Mec	IF FEMALE:	c. If yes, outcome of pregna	nov				004 D-to	of delicers
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Ö	at the de by the	ıysic	1 □ Yes 2 🖾 No 9 □ Unknown	9 Unknown	- J					
٠ <u>٠</u>	that ned b deta	by Pt	Part II. Other significant conditions conti			nderfying cause giv	en in Part I.	23e. Did t	obacco use contribu	ute to the cause of death?
g	w requires that s been signed t should be deta	ed b	Hypercapnic Respit	catory Failur	е			1 🔯	Yes 2 □ No 3	☐ Probably 4 ☐ Unknown
Division of Vital Records,	as be	Completed						24a. Was	psy pric	re autopsy findings available or to completion of cause of
œ e	/sician: The law s certificate has t director, page 2 s	E S						perfo 1 □ Yes	ormed? dea 2 No 1	ath?]Yes 2 □ No
)įta	cian: ertific	Be (25. Was case referred to medical examiner?	espital:		ot 3 DOA Oth	26. Place of Dea	ath (Check only	one)	
of	Physical direction	은	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 ☑ Inpatient 2 ☐	ER/Outpatier 28b. Time o	IL 3 LI DOA	4 LI Nursing F	T	idence 6 Other how injury occurred	
U _O	ding F h. After funera	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Wor	ḱ?]Yes 2 □No		,,	
/ISI	or Attending Physician: The law requires that the death certifical rafter death. Director: After this certificate has been signed by the attending is in by the funeral director, page 2 should be detached for use as	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he	ome, farm, str	eet, factory, office		28f. Location (Street and Number wn, State)	or Rural Route Number,
á	pital or purs after eral Dire	Certification: To	4 I Horridae	building, etc. (Specify	_					
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	cian: To the best of my kno er: On the basis of examina	wledge, deat tion and/or ir	h occurred at the to estigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) and mani , date and place, an	ner as stated. d due to the cause(s)
	To the Hos within 24 hα To the Fun completely	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen:	se number		29d. Date signed (Month, Day, Year)
	FSFÖ		1 Xxa			D6	6284		11/10/	2009
7	10		30. Name and address of person who con							
12	10		Suresh Malik, 730			Laurel, M	D 20707			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 1 2 2009	32. Registrar's Signa	are					
	150,151	100			-					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2000

			For State Registrar 1. Decedent's Name (First, Middle, La		Ce	rtificate of l	Death		leg. No.	3 38253
	Physici /Medic			ROBINSON				Month Nov.	Day Yea 6 200	ar
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of D	eath
1.			Prince Georges Ho			Chever			Prince	
l	Funeral Director		5/8-50-3659	7. Age (In)	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Aug. 4	, Year) , 1936	Birthplace (State or Foreign Country) DC
	deeth with the Maryland ms 23a or 28e-f show	J.	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🌣 No
	the M	Director	MD Prince (Georges H	yattsvi.	10f. Zip Code			10g. Citizen of What	
	a or	급		#1/0						Country
	ns 23	era	7527 Buchanan St.	12. Was Decedent Ever i	n U.S. 13.	20784 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - A	merican Indian,
320	be tiled within 72 hours after deeth with the Marylar tal Hygiene. d other than "natural", or Itams 23s or 28e-f show event, the Medical Expedient is ust be melified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)	Specify:	/hite, etc. Black
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ס	Hygin bther ent,	ပိ	17. Father's Name (First, Middle, Last		IC V	onde offi		e (First, Middle.	Maiden Sumame)	
Maryland	m = = 0	To Be	Matthew Hamilton				Marguer	ite Ste	wart	
ary	2 should and Men is marke sumatic	y - 2	19a. Informant's Name/Relationship (Туре, Print)	19b. Maili	ng Address (Street			r, City or Town, Stat	e, Zip Code)
_	is 1 and 2 should of Health and Me Item 27 is mark other traumation		Cheryl Townsend .	- Daughter	4108	Richley	Ct. Hyat	tsville	, Md. 207	84
9	of He		20a. Method of Disposition 1 Burial 2 Cremation 3		 b. Place of Disposer cemetery, cre 	osition (Name of matory or other place	ca)	Date	20c. Location - City	or Town, State
Ĕ	Pages ment of tent: If it		4 □Donation 5 □ Other (Special			n Nationa		3-2009	Suitland	
Baltimore,	permit. Pages Department of I Importent: If its any Injury or of		21. Signature of Funeral Service Lice	l Wood	M 4	arshall s 308 Suitl	ss funeral and Rd.	Home of Suitlan	Maryland d,Md. 207	46
ı			23a. Part1. Enter the disease, or cop shock, or heart failure. List only	plications that caused the cone cause on each line.						Approximate Interval Between
	Pnysician	3 1	Immediate Cause (Final disease or condition	. Cardiac A						Onset and Death
	/Medical		resulting in death)	Due to (or as a con		Y-2				
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9	titicati ig phy as the	ledicai		- v		TITLS	311.100			
C. Box	death cer e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 [XtNo 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of Month	delivery Day Year
7.	£ 8 €	by Pr	Part II. Other significant conditions	contributing to death but not	resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
ğ	w requires been sign should be	ted t						101	/es 2 □ No 3 □	Probably 4 ⊠Unknown
Vital Hecords,	he law te hes b age 2 sl	Completed						24a. Was autop perio 1 Yes	osy prior rmed? deat	e autopsy findings available to completion of cause of h? Yes 2 XNo
<u> </u>	icien: 1 certitical rector, p	Be	25. Was case referred to medical examiner?				26. Place of Deat			
0	Physicien: r this certific ral director,	ို	1 ☐ Yes 2 🛣 No	Hospital: 1 🖾 Inpatient			4 🗀 Nursing no	ome 5 Resid	dence 6 Other (Specify)
ב	ding P. After I funera	ion:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wor		28d. Describe I	now injury occurred	
2	tea tor:	cat	2 Accident investigation 3 Suicide 6 Could not be	e 200 Place of Injury	At home form of		Yes 2 □No	29f Location /	Stroot and Number o	r Rural Route Number,
Division	2 d g 6	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	reer, ractory, onice		City or Tox	vn. State)	n nuizi noute nuttoe.
	To the Hospitel within 24 hours a To the Funeral Completely tilled	Medical	29a Certifier 1 ▼ Cartifying P (Check only one) 2 ■ Medical Exa	nysician. To the best of my miner: On the basis of exar and manner stated.	knowledge, dea nination and/or in	th conumed at the two estigation, in my o	ne, data and place, pinion, death occur	and due to the red at the time,	date and place, and	due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (N	fonth, Day, Year)
)			Mani	anno		72	7577		11/07/200	19
	5		30. Name an address of person who	completed cause of death	(Item 23a) (Type	, Print)	_ //		, 0,,100	10.00
)		O. Cumberbatch,			r. Lando	ver, Md.	20785		
	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 2 2009	Registrar's S	ignature Saul	•				

DHMH 17 Rev 1/2001

09-08911

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 38264

Virgil Warren Ruark	1.	For State	St	ate o	f Marylan	id / Depa <i>Cer</i>	rtment <i>tificate</i>	of Hea	alth and a <i>th</i>	d Menta	al Hygie	ene Reg.) () (9 3826
Physician/	1	egistrar . Decedent's Name	e (First, Middl								L M	ate of Death	lav Year	3.	Time of Death
Medical Examine		a. Facility Name (i	f not institutio		GIL WAR		ARK, S		, Town, or	Location of		ovember 1	4c. County of I	Death	
	L	Peninsula F	Regional M						sbury	I was a	0411 10	Date of Birth	Wicomico (MM/DD/YYYY)		place (State or
Funeral Director	5	5. Social Security N		6. Sex	и 2 F	. Age (In yrs. Ia	ast birthday	y) If Ur Mon	nder 1 Year oths Days		Min.	5/18/	F	Foreign Coun	ARYLAND
		Jsual Residence o										0,10,	.,,_,		10d. Inside City Limits
w any		0a. State	10b. County			10c. City,	Town or L	ocation.	FIGU	mic c	DEEL			1	1 Yes 2 No
the Maryland a or 28a-f she iified at once		MARYLAND 10e. Street and Nu		RCHE	ESTER			10f. Z	FISE Zip Code	IING C	REEK	100	. Citizen of Wha	t Countr	ry?
the Ma is or 23 stified.			2640 HO	OPER	RS ISLAN	D RD.				21634				USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland operation of Health and Mental Hygiene. Important: I filem 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		11. Marital Status 1 Never Marri	ed 2 M	larried	12. Was Dece	ces?	.S. 13				in? (Specify Puerto Rica	y Yes or No- an, etc.)	14. Race - White,		an Indian, Black,
her dea		3 X Widowed			1 Yes f Yes, Give Year	2X No		Yes	2 X No	specify:			Specify:		WHITE
nours a		15. Decedent's E						edent's Usu				done	16b. Kind of Busi	ness/Ind	dustry
5-0036 ed within 72 hours afl tygiene. other than "natural" the Medical Examina Completed by		Elementary/Sec	ondary (0-12)		College (1-4	1 or 5+)		BU	JSINES	S OWN	IER		SEAFOC)D PR	ROCESSING
5-0036 led within 7 Hygiene. Lother than the Medica		17. Father's Name	(First, Middle	, Last)			L				's Name (Fir		aiden Surname)		
2121 and be fill Mental H marked c event, I		19a. Informant's N			ARREN R	UARK	19b. M	nailing Addre	ess (Stre	et and Num			HELMINA per, City or Town		
MD 2 d 2 shou lith and N m 27 is n aumatic					ARK, JR.	SON					, FISHIN	NG CREE	K, MD 216	34	
re, I s i and of Healt If item		20a. Method of Dis 1 🗶 Burial 2	sposition			20b.		isposition (I or other pla		metery,	Da	ate	20c. Location - (
altimore, rmit. Pages I ar spartment of Hee portant: If ite jury or other tr	1	4 Donation 5	Other S	Specify:				ER MEM 22. Name a			11/30/	/2009	CAM	BRID	OGE, MD
Bal permi Depar Impo		CURRAN-BROMWELL FUNERAL HOME, P.A., 308									_		RIDGE, MD 21613		
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										rt	Approximate Interval Between Onset and Death		
/Medical caminer	1	Immediate Cause or condition result		_	Multiple Inju		of):								- Doutin
			quentially list conditions, hy, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
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ited 3 ansit	LXa	events resulting in		d.	Due to (or as a	consequence (of):								
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3760, fricate be g physic s the bur		IF FEMALE: 23b. Was deceden		the	23c. If yes, o	utcome of pre	gnancy 2	Fetal de	ath 3	Ectopi	ic pregnancy	<i>y</i>	23d. Date of Month		Day Year
Box 6876: c death certificate the attending phy ed for use as the for	Physician/m	past 12 month		nknown	4 Pregna	ant at time of d		Other (1		
lecords, P.O. Box 6876: The law requires that the death certificate are has been signed by the attending phy age 2 should be detached for use as the least of the death of the	ڄ	Part II. Other sign			9 Unkno		resulting in	n the underl	ying cause	given in Pa	art I.	23e. Did to	bacco use contri	bute to f	the cause of death?
i, P.O.	200				<u></u>			_					2 V No 3		
ords w requi												24a. Was a autop	sy p	vere au prior to c death?	topsy findings available completion of cause of
Rec The la ficate h	Completed								26 Pla	so of Dooth	(Check onl	1 Yes		✓ Ye	es 2 No
/ital /sician:	o Re	25. Was case refe examiner? 1 ✓ Yes	2 No		lospital:	npatient 2	∕ ER/Outp	patient 3	DOA	Other ₄	Nursing I		Residence 6	Other	f:
Division of Vital Records, nation of Vital Records, rate of Attending Physician: The law require realth cleath. All Director: After this certificate has been signed in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	١	27. Manner of De	ath		28a. Date (Month, Nov 13,	of Injury Day Year)	28b. Tir 2206 l	me of Injury	i	jury at Wor	– iPa		now injury occurr of vehicle inv		in collision
Sion Attend r death. ector: by the f	Certification:	1 Natural 2 Accident		nding estigation	on	e of Injury - At	1		1	Yes 2 ✓	etc. 28	8f. Location (S	Street and Numb	er or Ru	ural Route Number, City
Divi	ert	3 Suicide 4 Homicide	de	uld not l termined	be	Major Ro					No	or Town, S orthbound F	state) Route 335, Chu	rch Cre	eek, MD
	calC	29a. Certifier (Check only one)	Certifying Medical Ex	Physici caminer	an: To the bes	t of my knowle	edge, death and/or inv	occurred a	it the time, n my opini	date and plon, death o	lace, and du occurred at t	ue to the caus he time, date	se(s) and manner and place, and c	as state	ed. ne cause(s)
Tot Tot com	Medical	29b. Signature ar			and manner s	tated.				nse numbe			29d. Date sign		
		Pote	- ()e	_	- to	Wel			0.0	C.M.E.			November	17, 20)
		30. Name and ad Patricia Ar				se of death (Ite ant Medica		ner 11	1 Penn	Street, B	Baltimore,	MD 2120	1		
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Registr DHMH 17 Rev 1/200			DEC 0	12		- Comme	OR	GINAL.	A .						
DIMMILLY INDV 1/200	- 1						~ (1)								

2:35 P M

Maryland

1 🗆 Yes 2 屎 No

10d. Inside City Limits

Interval Between

VIEARD

1 Yes 2 No

ANNMOLIS

Onset and Death

9. Birthplace (State or Foreign

USA

White

or Attending Physician: The law requires **Division of Vital** funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 8118

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WATKINS

State

NOV 10 Registrar

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31. Date filed (Month, Day, Year,

900

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eugene E. Sehrt 20009 November 2:05 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) 6/23/1930 If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min Missouri Director 79 495-30-8897 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Maryland Edgewater 1 ☐ Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 Central Avenue 21037 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.' 0 Black, White, etc. <u>ک</u> 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. Korea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) pe 1 and 2 should be filed within 72 tof Health and Mental Hygiene.
If item 27 is marked other than "recorder traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 12th District Staff Manager AT&T Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Evelyn V. Pfeiffer Ervin S. Sehrt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Patricia A. Sehrt/ Wife 700 Central Avenue, Edgewater, Maryland 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11/13/09 Lakemont Cemetery Davidsonville, MD 21. Signatur Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending plant of for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year been signed by the should be detached P.O. conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Nown 24a. Was an 24b. Were autopsy findings available has page 2 s autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Sertifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed (Month, Day, Year)

Registrar

address of perso

31. Date filed *(Month, Day, Year)* **NOV 12**

WEEDSOD FUMBLU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 2009 Physician/ Gregory Francis Stanbro 09:34 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Millersville Bello Machre If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Social Security Number **Funeral** 1 ☐ M 2 ☐ F Days 04/1211/11956 Washington, D.C. Director 53 217-72-2438 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🖁 No rral", or items 23a or 28a-f sl Examiner must be notified Millersville Anne Arundel Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 1648 Millersville Road 21108 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I Hygiene. other than "natural", or à 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) N/A permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, ? Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Celia Elizabeth Kingmon Franklin Place Stanbro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Carvel Circle, Edgewater, Maryland 21037 Roberta G. Fagan/Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-12-09 Washington, DC Rock Creek Cemetery service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Desouta disease or condition al phemiss resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death Yes 2 No sate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: Hospital: 4 Nursing Home 5 Residence 6 X Other (Spec 2 🖭 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 1 🔲 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe Hechoel veratz to D19667 November 10, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael H. Schwartz, 7310 Richie Highway, Suite 508, Glen Burnie, MD 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

NOV 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2009 4:52 PM November Peggy Joan Sipes Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) If Under 2 **Funeral** Days Min. (Month, Day, Year) 12/18/1942 1 □ M 2 🕱 F Months 66 Washington, Director 224-58-2103 Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 🔀 Yes 2 🗌 No **Beltsville** Prince Georges MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20705 US 3416 Dunnington Road 'natural", or items hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc. 1 Never Married 2 x Married 1 ☐ Yes 2 ☑ No If Yes, Give ģ Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: White Specify: 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) : should be file n and Mental H is marked oth Virginia Mae King Hubert Lionel Benson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3416 Dunnington Rd. Beltsville, MD Richard N. Sipes / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 11/21/2009 Brentwood, MD. . Signatur of Funeral Se 22. Name and Address of Facility Fort Lincoln Funeral Home License Marcis 3401 Bladensburg Rd. Brentwood, MD. 20722 Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail or, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin 1 Pnysician/ Sensis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Morbid Obesity 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of page 2 : 1 Yes 2 No Yes 2 K N this certificate 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 2 X No မှ 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗀 No 2 Accident
3 Suicide
4 Homicide М Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital

24 hours after death Funeral Director: filled in by

State

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashish Tolia, M.D.

1500 Forest Glen Rd

31. Date filed (Month, Day, Year) **NOV 1** 7 2009

determined

Registrar's Signature

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c, License number

H64588

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Silver Spring, MD

29d. Date signed (Month, Day, Year, November 11, 2009

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** STONE ZELLRENE Ε. NOVEMBER 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHEVERLY

The state of the stat PRINCE GEORGE S

9. Birthplace (State or Foreign PRINCE GEORGE'S HOSPITAL 8. Date of Birth (Month, Day, NOV . 8 Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Months 1 ☐ M 2 □ YF 82 Yrs. JAMACIA Director 579-72-6369 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evaniner must be ruitled at 14 Yes 2 No Director NEW CARROLLTON PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with USA 20784 #202 5434 85th AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 □Yes 21 No <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE NURSE 1yr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDNA GREENE NEHEMIA HALL မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5434 85TH AVENUE # 202 NEW CARROLLTON, MARYLAND 20784 ADOLPH HENDERSON/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State ADELPHI, MARYLAND 11/20/2009 GEORGE WASHINGTON 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME Signature of Funeral Service Licensee 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final our 1 **Physician** resulting in death) /Medical Due to (or as an insequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably ≒ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 12 Yes 2 □ No 2 ☐ ER/Outpatient 3 ☐ DOA 11 Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely within 2. and manner stated.

State Registrar ame 32. Registra's Signa

address of person who completed cause of death (Item 23a) (Type, Print).

29b. Signature and title of certifier

30. Name and

Alcras

ORIGINAL

29c. License number

MINCE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Ĩ1, 7:55 A. 2009 November Evelyn Louise Elizabeth Smith /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Beltsville 3414 Cherry Hill Court If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🗗 F Washington, D.C. Aug. 6, 203-46-0562 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 'natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Beltsville MD Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20705 United States 3414 Cherry Hill Court Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ MNo Specify: If Yes, Give Year or Dates 3 Widowed W Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Ann Panholzer Wilbur Joseph Jackson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3414 Cherry Hill Court, Beltsville, MD 20705 Elisa Jackson/Daughter 20h Place of Disposition (Name of November 2009 20c. Location - City or Town, State 20a. Method of Disposition George town University Medical Center 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Licenses /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final month Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Phystclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical for use as yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 \subseteq Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 I Inknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 2 🗆 No 1 ☐ Yes **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No Hospital: 5X Residence 6 ☐ Other (Specify) 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of eath 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No death. after death 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

Name and addre

31. Date filed (Month, Day,

NOV 16

2009

to completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		•	For State	State of Ma	_	-	t of Health e of Death			jiene Reg. No.2 (nna	38271
			Registrar 1. Decedent's Name (First, Middle, La	nst)		yor umouto	or Boats		2. Date of Dea	th		3. Time of Death
	Physicia Medic		PAULINE	SI	LAS				NOVEMB	ER 8	2009	11:55 P ^M
	Examin		4a. Facility Name (if not institution, giv	100000000000000000000000000000000000000			Town, or Locatio	on of Death			nty of Death	
•	Funeral		SOUTHERN MARY 5. Social Security Number 6.5		AL In yrs. last birtho			ier 24 Hrs.	8. Date of Birth	1	9. Birth	ORGE S
	Director		579-24-2532	1 □ M 2 XF 9	1 Yr	s. Months	Days Hours	s Min.	(Month, Day JUNE 25	1918	SOUT	H CAROLINA
	how at	'n	Usual Residence of Decedent 10a. State 10b. County	· I	10c. City, Town o	r Location						10d. Inside City Limits
	farylar Ba-f s tiffed	Director	MD PRINCE	GEORGE'S	FORESTV	LLE						1X Yes 2 □ No
	a or 2 be no	i Di	10e. Street and Number			10f. Zip	Code			10g. Citizen o	f What Cou	intry?
	th with ms 23 must	Funeral	2100 BROOKS DRI				0747	0.1-1-0.10	-' V N-	US		
(0	or iter	by Fu	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 💢 N		If Yes, speci	ent of Hispanic (ify Cuban, Mexic	can, Puerto	Rican, etc.)		ace - Ameri lack, White,	, etc.
80	ırs aftı ural", IExar	ted t	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1 Tes 2	2 X No Speci	ify:		Spec	fy:	BLACK
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212	vithin giene. er thar the N		Elementary/Seconday (0-12)	College (1-4 or 5+	, I	CLERK	reureaj			GO	VERNM	ENT
nd	filed valued by defined valued by defined valued by defined by def		17. Father's Name (First, Middle, Last)				18. Ma	other's Name	e (First, Middle, I			
yla	uld be I Ment narke natic	2	JOHNNY YOUNG					KNOWN				
Maryland 21215-0036	12 sho lith and 27 is I		19a. Informant's Name/Relationship (OSLEY SILAS J	• • • • • • • • • • • • • • • • • • • •			(Street and Num OKS DRIV		l Route Number, .04 FORE	-		YLAND 20747
Baltimore,	of Hea of Hea fitem		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 [20b. Place of D	isposition (Nam	e of		Date	20c. Locatio	n - City or T	Town, State
ţi	. Page tment tant: I jury o		4 Donation 5 Other (Spec	ify)	-	CEMET		<u> </u>				RYLAND
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Liber	nsee	n n		Address of Fac LANDOVI					AL HOME D 20785
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused to one cause on each line.								Approximate Interval Between
-	nysician/ Medical	i	Immediate Cause (Final disease or condition resulting in death)	a	Find This equence of)	stag	e Ren	al	direa	se		Onset and Death
	Examiner		resulting in death)	Due to (or as a	The sequence of)	600	c					
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	icate be executed I physician and s the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c	consequence of)						\rightarrow	
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8760	ificate ig phy as the		IF FEMALE:									
Box 68	th cert ttendir or use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	☐ Fetal death	3 🗌 Ectopic p					Date of delived	very Day Year
. B	requires that the death certific been signed by the attending should be detached for use as	by Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at i 9 ☐ Unknown	ime of death	5 Other (sp	ecify)				nontri	Day rou
9. 0.	that the ned by e deta	oy Pł	Part II. Other significant conditions	contributing to death bu	not resulting in	the underlying o	ause given in Pa	art I.	23e. Did to	bacco use co	ntribute to 1	the cause of death?
ds,	equires en sig ould b	ted							1 🗆 Y	es 2 No	3 🗆 Pro	obably 4 🗆 Unknown
COL	law re has be e 2 sh	Completed							24a. Was a autop	sy	o. Were auto prior to co death?	opsy findings available ompletion of cause of
<u>~</u>	ician: The certificate rector, pag		25. Was case referred to medical				26. Place of D	South (Charl		2 No	1 Yes	2 No
Vita	ysicia is certi directo	To Be	examiner?	Hospital:	nt 2 🗆 ER/Outp	atient 3 DC	Other:		me 5 Resid	ence 6 🗆 O	ther (Specif	(v)
of	ing Ph (fter th uneral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,	28b. Tin	ne of 28	Bc. Injury at work?	- 1	28d. Describe h	ow injury occi	ırred	
sion	l or Attending I after death. Director; After I in by the funer	Certificate:	2 Accident Investigation 2 Suicide 6 Could not	be 280 Place of Injur	/ - At home, farm	M M	1 Yes 2		28f Location /S	treet and Nun	aber or Run	al Route Number,
Division of Vital Records, P.O.	tal or A Irs after al Direct led in by		4 ☐ Homicide determined	building, etc.		, otroot, ractory			City or Town		ibei oi naie	ar noute Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	ysician: To the best of m niner: On the basis of exa se Practioner: To the b	mination and/or i	nvestigation, in r	ny opinion, death	occurred at	the time, date ar	nd place, and	due to the ca	ause(s) and manner stated.
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			1. Tak	lun all	IVIX		D003	54	144	11/	9/	2004
N	7		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Ty	pe, Print)	3 HO	spit	al Dri	VE C	36	MD 2073
	Sta Registra		31. Date filed (Month, Day, Year) NOV 1 6 2009	32. Registra	s Signature	1	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 10 Year 2009 2:50 P M RAYMOND SAVOY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S LANHAM MAGNOLIA CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 11 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 □XM 2 □ F Months Days Hours Min. MARYLAND 1950 54 213-56-0294 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 MINNA AVENUE 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2X No Specify BLACK Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH AUTO MECHANIC PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS J. SAVOY SOPHIE WALLACE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

911 MINNA AVENUE CAPITOL HEIGHTS, MARYLAND 20743

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

11/13/2009 RIVERDALE, MARYLAND

Date

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Im Medical Evantment in 1st Le marked once. Baltimore, Maryland 21215-0036

Physician

Examiner

Funeral

Director

/Medical

10a. State

Director

Funeral

Completed by

Be

2

CHRISTINA SAVOY/DAUGHTER

5 ☐ Other (Specify)

1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State

20a. Method of Disposition

29b. Signature and title of certification

HINA 31. Date filed (Month,

NOV 1 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED M.D.

4 Donation

Physician /Medical Examiner

il or Attending Physician: The law requires that the death certificate be executed after death. and burial-tran physician the use as ō ģ s been signed b should be deta page certificate ou's after death.

er I Director: After this of filled in by the funeral director.

P.O. Box 68760,

Division of Vital Records,

Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) <u>METASTATIC</u> COLORECTAL CANCER Due to (or as a consequence of) ACUTE RENAL FAILURE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ANURIA Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? autopsy 2**X** No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

D0063918

7525 GREENWAY CENTER DRIVE GREENBELT, MARYLAND 20770

20b. Place of Disposition (Name of cemetery, crematory or other place)

RIVERDALE CREMATORY

DHMH 17 Rev 1/2001

State

Registrar

24 hou s a Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician F. Strong 2:30A LaDonna 8,2009 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Temple Hills 2602 Fairlawn Street Prince Georges If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last hirthday) **Funeral** Months Days 1 □ M 2 🕅 F Director Jan. 24, 1972 Wash., DC 37 577-86-2062 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examirer must be notified at 1 XYes 2 ☐ No Director Temple Hills MD PG 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20748 United States 2811 Colebrooke Drive by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11 Marital Status Black White etc. 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 🛣No Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Office Manager Private s 1 and 2 should be filed wi f Health and Mental Hygier item 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francenia Reeves Henry Strong ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2602 Fairlawn Street
Temple Hills, MD. 20748 19a. Informant's Name/Relationship (Type. Print) D. partment of Health ar Important: If item 27 Is any Injury or other trau Francenia Strong/mother Baltimore, 11/14/09 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1

■ Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee away 3910 Silver Hill Rd., Suitland, Md. 20746 . Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late Cause (Final Physician BREAST YGARS RIGHT CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CANCER BREAST LIVER METASTATIC Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner be executed ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) signed by the a Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 2 No 1 🗆 Yes al or Attending Physician: 's after death.
Il Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) PARENTS Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

MATILDA 31. Date filed (Month, Day, Yea NOV 1 3 2009

atilda H.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MERCANTILE LANG, 1221

State

29c. License number

026250

29d. Date signed (Month, Day, Year)

hovember 10,2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** LAUREL STOVE 5:05A M NOVEMBE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE NORTHWEST HOSPITAL RANDALLSTOWN | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral 1⊠M 2□F Director 579-66-1203 58 July 3, 1951 Wash., DC Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 □ No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2304 Hartford 20020 St., S.E. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private 12th Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked oth any linjury or other traumatic event once. Be Elbeth Davis Fred Stove 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2304 Hartford St., SE #303 Wash., DC Edith Campbell / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 11-14-09 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Lic nsee 22. Name and Address of Facility Capitol Mortuary 20002 1425 Maryland Ave., NE 23a. Part 1. Enter the disease, or shock, or heart failure. List of complications that caused the death. Do logenter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Liver Due to (or as a confequence of): **Physician** /Medical Examiner Circhosus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): that the death certificate be executed physician and the burial-transit Hepathts C Due to (of as a consequence of). Box 68760, attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) Ö 9 Unknown ģ σ. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by The law requires Carcinoma Nasopharyngeal 1 Yes 2 No 3 Probably 4 Unknown Valve Endocardity 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page Chronic Portal Voin Thrombosis 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 No of Vital Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 DOther Specify Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident Injury Division 5 Pending ours after death. neral Director: A filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 24 hours 1 🗗 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H45931 November 6 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown MD 5401 OLD COURT Road urton 31. Date filed (Month, Day,) NOV 1 3 2009 State Registrar

			For State	State of	f Marylan		ertment of F tificate of L		nd Mental Hy	20	09 38275
		-	Registrar 1. Decedent's Name (First, Middle	e, Last)			uncate of L	Jean	2. Date of De		3. Time of Death
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	within 72 hours after death with the Maryland glene. ier than "natural", or items 23a or 28a-f sho it, the Medical Examiner must be notified at	Funeral Director	121 Q St.,	N.W.			20	001		Unite	d States
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(687	eath certifical attending ph I for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregnate Birth 2 - Feta	ncy	Ectopic pregnanc	27		23d. Date	of delivery
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σ.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transif	by	Tart II. Other significant conditi	Jis contributing to de	atti but not rest	aiting in the u	idenying cause gr	ven in raici.			oute to the cause of death? 3 □ Probably 4 🔀 Unknown
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on	Attending I er death. ector: After by the funer	ficat	1 Natural 5 ☐ Pendii 2 ☐ Accident Investi	igation	h, Day, Year)	injury	M 1 🗆	Yes 2 N	lo		
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DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 8. Day 2009 3:27 P William Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 75 vrs If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Nov 9 1933 Days Hours Min. 1 X XM 2 - F OkTahoma Director 550-44-7402 Usual Residence of Decedent or 28a-f show 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Temple Hills 1 Yes 2 K No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 3600 Fernandes Drive 20748 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 x Married 1 x Xes 2 No If Yes, Give 1978 Saltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Retired permit. Page 1 and 2 should be filed within 72 hours pepartment of health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) year U.S. Air Force Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alexander Mavbelle Fred Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 Fernandes Drive Temple Hills, MD 20748 Audrey Smith / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Vet. Cemetery 11/13/2009 Cheltenham, Maryland 22. Name and Address of Facility of Funeral Service License George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland PMt 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events death certificate be executed resulting in death) Last physician a s the burial-1 Physician/Medical Box 68760 attending p yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No 9 Unknown signed by the a d be detached f Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy Yes 2 25. Was case referred to medical examiner? **Division of Vital** director, Be 26. Place of Death (Check only one) 2 XNo Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After work?
1 Yes 2 No 5 Pendina n 24 hours after death.

le Funeral Director: Aff
bleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within . only one 29b. Signature and title of o 53200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) urralts Pa State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:44 PM M. T. Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctors Community Hospital Lanham Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Tennessee **Funeral** 8. Date of Birth 295-10-2663 96 Days Hours Min Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits MD Prince George's Lanham 1 Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10212 Buena Vista Avenue 20706 United States items ; Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ò ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 "natural", 3 → Widowed 4 □ Divorced 1 ☐ Yes 2 X No Specify Specify: Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Director for Dep't of Recreation D.C. Gov't Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida (unknown) and Mental Fis marked o Jesse Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Lanham, MD 20706 Jesse Richards (friend) 10216 Chautauqua Ave 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 11/17/2009 Brentwood, MD Signature of Funeral Service Libensee 22. Name and Address of Facility Fort Lincoln Funeral Home Lectron 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar
DHMH 17 Rev 7/2009

RDAD.

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30, Name and addiess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 10:09 a^M Physician November JYMAN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Cheverly Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 □ M 2 1 F **Funeral** Columbia, 12-25-1919 89 056-18-8006 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State 1 X Yes 2 ☐ No 28a-f show ir than "natural", or items 23a or 28a-f sho the Modical Examinar must be motified at Director P.G. Bowie MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20721 1001 Kings Heather Drive Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Sydaham Hospital Union Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Lee Pages 1 and 2 should be a nent of Health and Mental Willa Clayton William ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m any injury or other traum once. 1001 Kings Heather Drive, Bowie, Maryland 20721 Turman - Son Steve Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Riverdale Pk Crematory 11-6-2009 | Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home 21. Signure of neral Service Licensee 101 10583 Middleport Lane, White Plains, Maryland Komol 23a. Part 1. Enter the disease, or complications that cell ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Conjestive Heart Failure **Physician** resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant et time of death use Year 23h Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 mon 1 Tyes 2 2 No for 1 5 ☐ Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown <u>ک</u> Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ② No Atrial Fibrillation page 2 s has 2 🖺 No 1 ☐ Yes 1 ☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1∐Yes 2⊠No 1 🔀 Inpatient Certification: To this 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After the 5 Pending investigation Natural Natural 1 □Yes 2 No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

CR 2

State Registrar 31. Date filed (Month, Day, Year) NOV 1 2 2009

and address of pe

30. Name



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009

			For State Registrar	ate of Maryland / Dep <i>Ce</i> e	artment of Health rtificate of Death	and Men		ne no.2009	38279
	Physicia		1. Decedent's Name (First, Middle, Last) Doris Marie The	ompson		N	Pate of Death	8, 2009 Year	3. Time of Death 19:03 M
	Medic Examin		4a. Facility Name (if not institution, give street a	nd number)	4b. City, Town, or Location			4c. County of Death	-1
			Southern Maryland House 16. Sex	<u> </u>	Clinton If Under 1 Year If Under	r 24 Hrs. I a D	ate of Birth	Prince Ge	Porges place (State or Foreign
	Funeral Director		578-76-4732 1 □ M 2	7. Age (In yrs. last birthday) 52 Yrs.	Months Days Hours		Nonth, Day, Yea	57 Wash	ington, D.C.
	nd show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla 28a-f s xiffied	Director	Maryland Prince Geo	rges Capitol	Heights				1 [¥] Yes 2 □ No
	h the l Ba or 2 be no	al Di	10e. Street and Number		10f. Zip Code			Citizen of What Cou	-
	ath wit	Funeral	6801 Jade Court 11. Marital Status 12. W.	as Decedent Ever in U.S. 13.	20743 Was Decedent of Hispanic Or	rigin? (Specify Y		United Sta	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1	Yes 2 X No	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical 1 ☐ Yes 2 ☑ No Specify		, etc.)	Black, White,	etc.
215-0	יי 72 hou an "natu Medica	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Seconday (0-12)	npleted) (Give	dent's Usual Occupation kind of work done during mos OO NOT use retired)	st of working	- 4	o. Kind of Business In	
212	ygiene ygiene her th t, the	Be Co	12		DA Graduate			Governmen	<u> </u>
and	oe filec antal H ced ot c ever	To B	17. Father's Name (First, Middle, Last) John Wesley Jones,	Sr		her's Name <i>(Fir</i> s nnie Av		len Surname)	
ary	Ind Me s marl umati		19a. Informant's Name/Relationship (Type, Pri		ing Address (Street and Numb			or Town, State, Zip	
Σ	and 2 sleatth a tealth	Donald Thompson, Jr		9 Reverend Bou					
Baltimore, Maryland 21215-0036	Page 1 ann of Hant of Hant of Hant of Hant of Hant or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify)	allioni state	matory or other place) Memorial	Date 11/16/2	- 1	andover,	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service License	M MOLDES 2	2. Name and Address of Eacili Alexander S 5538 Maribor	o Pike/	P _F A.	ville, Md	. 20747
П			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus	ns that caused the death. Do not ent					Approximate Interval Between
F	nysician/		Immediate Cause (Final disease or condition	ANOXIA					Onset and Death
	Medical Examiner		resulting in death)	Due to (or proceduence of):		0			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of).	enso				
	ecuted and transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of):	Moura	non			
0	icate be executed physician and sthe burial-transit	edical E	resulting in death) Last	Bue to (c) as a consequence ely.					
976	ificate ig phy: as the	Medi	IF FEMALE:						
Box 68760	hat the death certificed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			23d. Date of delive	ery Dav Year
B	he dea y the a ched fi	nysic		Pregnant at time of death 5	Other (specify)				
P.0	that the	by Pi	Part II. Other significant conditions contribut	ing to death but not resulting in the	underlying cause given in Part	tl.		co use contribute to t	
rds,	een sig	eted	_						bably 4 Unknown
eco	e law requires that to has been signed by ge 2 should be dett	Completed			90		24a. Was an autopsy performed	prior to co	ppsy findings available empletion of cause of
a R	an: Th tificate tor, pa	Be Co	25. Was case referred to medical		26. Place of Dea			No 1 ☐ Yes	2 L No
Zit	hysici his ce al direc	잍	examiner? 1 ☐ Yes 2 No Hospit.	1 Inpatient 2 ER/Outpatie				e 6 Other (Specif	y)
n of	ding P th. After t funera	cate:	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 Yes 2		Describe how in	njury occurred	
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending bhysician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. L	_ocation (Street City or Town, St	t and Number or Rura tate)	l Route Number,
۵	hours a	Medical (29a. Certifier 1 Certifying Physician:	To the best of my knowledge, death	occured at the time, date and	d place, and due	to the cause(s	s) and manner as stat	ed.
	the Hk hin 24 the Fu mplete	Mec	only one) 3 Certifying Nurse Prac	the basis of examination and/or investioner: To the best of my knowledge,	death occurred at the time, dat	te and place, and	d due to the cau	ise(s) and manner as s	tated.
	vit or or		29b. Signature and title of certifier	VC	29c. License number	540	29d.	Date signed (Month,	∪ay, Year)
: //	25		30. Name and address of person who comple	ted cause of death (Item 23a) (Type,	Print)	nton	mal	11/1726	
ノバ	Sta	te	31. Date filed (Month, Day, Year) NOV 1 2 2009	32. Registrar's Signature	DHILLI	mon	, 1110	301))
	Registr	ar	NUV 1 2 2009 Reven	a D. Marks					

		1	State of Maryle		artment of H tificate of D		lental Hygier Reg.	ne No. 2009	38280
	Physicia	n/	1. Decedent's Name (First, Middle, Last) ELSA B. VASQUE	>			2. Date of Death	Day Year / 2004	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number) 8604 Riggs Road		4b. City, Town, or Adelpl	Location of Death		4c. County of Death	
	Funeral Director			rs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 12/3/19		hplace (State or Foreign Intry) th America
	the Maryland a or 28a-f show be notified at	irector	Usual Residence of Decedent	City, Town or Loc Adelph			109.	Citizen of What Co	10d. Inside City Limits 1 🛣 Yes 2 □ No untry?
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funera	8604 Riggs Road 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12. Was Decedent Ever in Armed Forces? 1 □ Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)	16a. Decec	f Yes, specify Cuba I ☑ Yes 2 □ No dent's Usual Occup	spanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)	USA 14. Race - Amer Black, White Specify: His	e, etc. Spanic
nd 212	e filed withir ital Hygiene ed other tha event, the	l as l	17. Father's Name (First, Middle, Last)	Real	l Estate		e (First, Middle, Maid a Pitre	Private den Surname)	
Maryla	and 2 should be fill Health and Mental tem 27 is marked of ther traumatic evo		Mauricio Daza 19a. Informant's Name/Relationship (Type, Print) Mario Vasquez / Husband	I			l Route Number, City	y or Town, State, Zip	o Code)
imore,	Page nent c ant: If any or		20a. Method of Disposition 2 Permoval from State	ort Linc	oln Cemet	ery 11/1	7/2009 B ₁	c. Location - City or	MD.
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Censee 23a Part 1. Enter the diea s, or complications that caused the	3	401 Blade	ensburg Ro	t Lincolr		Home 20722 Approximate
	ate be executed Medical Examiner the burial-transit	dical Examiner	23a Part 1. Enter the d'ea a, or complications that caused the dshock, or heart filure. List only one cause on each line. Immediate Cause (F) all disease or condition resulting in death) Sequentially list conditions, it any lead of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause injury that initiated events resulting in death) Last Due to (or as a condition of the cause injury that initiated events resulting in death) Last	sequence of:	Hear	+ Disec	se		Interval Between Onset and Death The Maria
. Box 6876	ath certific attending p for use as	₩ We	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of de Month	livery Day Year
Is, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but no	ot resulting in the	underlying cause gi	ven in Part I.			o the cause of death?
of Vital Records,	The law req	Completed by					24a. Was an autopsy performer	prior to death?	topsy findings available completion of cause of
ital	ysician: The la nis certificate ha director, page /a	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 🗌 ER/Outpatie	Oth	lace of Death (Chec	k only one) ome 5 A Residence	o 6 Other (Spec	nife)
on of V	ttending Physiquesth.	Certificate: To	27. Manner of Death 1	28b. Time o	f 28c. Injur	y at	28d. Describe how i		aryy
Division	spital or Attend nours after death neral Director: A filled in by the f		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (Sp.		reet, factory, office		28f. Location (Stree City or Town, S		iral Route Number,
N	To the Hospita within 24 hours To the Funeral completed filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my keep only one) 2 Medical Examiner: On the basis of examination of the basis of the basi	nation and/or inves	stigation, in my opini death occurred at the	on, death occurred a ne time, date and pla-	t the time, date and poet, and due to the car	lace, and due to the use(s) and manner as	cause(s) and manner stated. stated.
λ,	To to to com		29b. Signature and title of certifier Susan H. Khuegen		29c. Licens	H838	29d	Date signed (Mont	n, µay, year) 9
_			30. Name and address of person who completed cause of death		Print) Defe	rse Hw	y Anni	ap. Ms	21401
	Sta Registi		31. Date flod Manth P2009 Several 32. Registra's S	Signature de la companya de la compa					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3828 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Mary C. Widmayer 2009 2:55 P M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 55 Decatur Avenue Annapolis 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** (Month, Day, Washington, 1 □ M 2 XX 578-52-9150 72 Director Nov. DCUsual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director Annapolis Maryland Anne Arundel 1 Yes 2XXNo 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 U.S.A. 55 Decatur Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black White etc. 1 Never Married 2 Married Completed by Yes 2 YNO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Year or Dates 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than Administrator Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Salley Thomas F. Collins, MD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Widmayer/son 1602 Bay Ridge Avenue Annapolis, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place) 1 🗆 Burial 🙎 Cremation 3 🗀 Removal from State any injury or Baltimore Crematory 11/10/2009 BAltimore, Maryland 4 Donation 5 Other (Specify) Funeral Savice License Signature 22. Name and Address of Facility John M. Taylor Funeral Home 1004 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOUR PU Kemia Physician/ disease or condition Medical resulting in death) Examiner LOC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence hemo thera Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Carr ev Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death the g Unknow Division of Vital Records, P.O. þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 1 Tyes been signatures Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy To the Hospital to
within 24 hours after death.
To the Funeral Director. After this certificate!
......nieted filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🖪 Na 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home ၉ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural injury 5 Pending M Accident Investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 052830 November 9,2009 wein

State Registrar 31. Date filed (Month, Day, Year)

NOV 10

Bestaate

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

O Q o O | Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Do OW 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nu Examiner mul Anna Pous Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 X M 2 □ F 13, 1943 Texas 163-36-1131 66 Apr. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ?? is marked other than "natural", or items 23a or 28a-f sho traumatic event, tre Medical Evantiner must be rediffed at 1X Yes 2 □ No Director Bowie Prince George's MD Pages 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20715 USA 3504 Mabank Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1961–82 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 9 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 permit. Pages 1 and 2 should be filed withir. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, ITe Ms. College (1-4or 5+) Medical Labratory Technician | Hospitals 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Izetta Finchorn Robert L. Womack, I 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bowie, MD 20715 3504 Mabank Ln. Edda Carlotta Womack spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/2009 Arlington, VA Arlington Nat'l Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home Lineral Service Censee Bowie, MD 6512 NW Crain Hwy. 23a. Part. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus in inal disease or condition resulting in death) eas. Days **Physician** noonic /Medical Due to (or as a consequence of): **Examiner** Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1X Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ...
autopsy
performed? 2 No 1 ☐ Yes 1 ☐ Yes 25. Was ca er ferred to media examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide i 24 hours af e Funera! D iletely filled in 1 × Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my onlines death accurred. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ည

State Registrar 31. Date filed (Month, Day,

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nes H. White		State of Mary	land / Depa	rtment of F	Health and					09 3	828
_		I- For State Registrar	Cer	tificate of L	Death			Reg. I			
Physicia dical Examin		Decedent's Name (First, Middle,Last) JAMES HENRY WH	מד מידו				Mo	te of Death onth Da vember 6,	y Year	3. Time of De 1010 hr	
CUICAI EXAIIII	ici	4a. Facility Name (if not institution, give street and		4b.	City, Town, or	Location of I		verriber 0,	4c. County of De	ath	
		Easton Memorial Hospital			Easton				Talbot		
Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ist birthday)	If Under 1 Year		Min	,	MM/DD/YYYY) 9. Fo		
Director		219-26-7063 1X M 2 F	70	Yrs.	MOTHITS Days	S Hours	FE	BRUARY	16, 1939	eign Country	AND
any		Usual Residence of Decedent 10a. State 10b. County	10c, City,	Town or Location	. <u> </u>				10d. Inside City Limits		
*						SONVIL	T F			1 Yes	2 X No
daryland 28a-f show 1 at once.	Director	MARYLAND QUEEN ANNE 10e. Street and Number	<u> </u>		10f. Zip Code	OHVIII		10g.	Citizen of What C	Country?	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene tent and Mental Hygiene tent 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once.		107 HISSEY ROAL)		21	638			UNITED S	STATES	
n with	Funeral		Decedent Ever in U. d Forces?		Decedent of His				14. Race - Ar White, etc	nerican Indian, Bl	lack,
	Fun	1 Ye	s 2 X No		es 2 X No			,	Specify:	WHITE	
rs afte ural",	þ	3 Widowed 4 Divorced If Yes, Give or Dates: 15. Decedent's Education (Specify only highest or Dates)		16a. Decedent's			nd of work de	one 16	Sb. Kind of Busine		
72 hou "nat	eted		e (1-4 or 5+)	during mos	t of working life	DO NOT us	se retired)				
5-0036 led within 72 Hygiene. other than '	Completed	12		DEL	IVERY P					ETAIL	
15-0 illed w Hygic d othe	Co	17. Father's Name (First, Middle, Last)	·						den Surname) N HUGHES		
2121 ould be fi Mental I marked	o Be	JAMES H WHITE, SR 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing A	Address (Stree				r, City or Town, S		
MD 2 nd 2 shou alth and M m 27 is n aumatic	То	VERONICA L. WHITE/WIFE			,				WILLE, N		21035
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Institute 27 is marked other than "natural"; or other traumatic event, the Medical Examiner.		20a. Method of Disposition		Place of Dispositi		metery,	NOVEMB	ER 10 2	0c. Location - Cit	y or Town, State	
Pages ent of nt: If		1 Burial 2 X Cremation 3 Remove 4 Donation 5 Other Specify:		crematory or othe CHESA REMATION			2009		STEVENSV	ILLE, MA	RYLAND
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other transmatic event, the Med	ı	21. Su nature of Funepal Service Licensee	32 \	FE13	COWSAddrH	ELFENI	BEIN A	ND NEW	NAM FUNE	RAL HOME	E, P.A
	1 1	23a. Part I. Enter the disease, or complications the	Magued the death	408	SOUTH	LIBER	TY STR	REET, (Shock, or heart	LE, MD Approxima	
Physician		failure. List only one cause on each line.		. Do not onto the	, mode of dying	, cacir as sai	, alac or toop	, , , , , , , , , , , , , , , , , , , ,	,	Between (Onset and eath
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Due to (or a	as a consequence o	f):							
	L	Sequentially list conditions, b.		Δ.							
	ine	cause. Enter Underlying Cause	as a consequence o	т):							
ed isit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or a	as a consequence o	f):							
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60, ate be hysicia e buria	Med		es, outcome of preg	nancy		-	_		23d. Date of de	ivery	
Box 68760, c death certificate be the attending physici	Physician/Me	nast 12 months?	ve birth regnant at time of de		al death 3	Ectopic	pregnancy		Month	Day	Year
Sox leath c e atten for us	ysic	A TO Man of The O The Indianama To The	nknown	eath 5 Othe	er (Specify)				i e		
		Part II. Other significant conditions contribution	ng to death but not r	esulting in the un	iderlying cause	given in Par	rt I.		acco use contribu		
res that the signed by	d by						_		2 No 3		
rds v requi	olete							24a. Was an autopsy	prio	re autopsy finding r to completion of	
Recc The lar	Completed							perform 1 🗸 Yes 2		Yes 2	No
Division of Vital Records, ours afternation of Attending Physician: The law requirement and Directors. After this certificate has been siftled in by the funeral director, page 2 should the control of the funeral director, page 2 should the filled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Bec	25. Was case referred to medical examiner?			_	IOthor:	Check only of				
of Vit ing Physic After this	10	1 Yes 2 No		ER/Outpatient 28b. Time of In		ury at Work?	Nursing Ho		esidence 6 (Other:	
n o ding h. fune	Certification:	27. Manner of Death 28a. D	Date of Injury Month, Day Year) 6, 2009	0915 hrs		Yes 2	Ped		ruck by auto		
ivision or Attendafter death Director:	icat	2 Accident Investigation 28e.	Place of Injury - At h	nome, farm, street	t, factory, office	building, etc			eet and Number	or Rural Route Nu	umber, City
Div Hospital or 4 hours afte Funeral Dir ely filled in	ertii	Colorec	cify) Major Roa	ıd / Highway			US F	or Town, Sta Rt 50 at Exi	t 45A, Grasonv	ille, MD	
Di To the Hospital within 24 hours a To the Funeral I		29a. Certifier 1 Certifying Physician: To the	best of my knowled	ige, death occurr	ed at the time,	date and pla	ce, and due	to the cause	(s) and manner as	stated.	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the ba	esis of examination a ner stated.	and/or investigation		on, death occurrence number	ourred at the		nd place, and due 29d. Date signed		ar)
	Σ	29b. Signature and title of certifier	\bigcirc			.M.E.			November 7,		/
MC		30. Name and address of person who completed	cause of death /Itor	n 23a)							
מוץ		Ling Li, MD Assistant Medical E		Penn Stree	t, Baltimore	, MD 212	01				
S	tate	31. Date filed (Moral 1977), Y at 2 2009 32	Registrar's Signal	turg L	v. 1					· · · · · · · · · · · · · · · · · · ·	-
			and the second second second								

State 31. Date filed (Moi Registrar

parker

			State of Maryland / Department	rtment of F tificate of I		ntal Hygie	ene 1. No 2009	38284
			Decedent's Name (First, Middle, Last)		2.	Date of Death	Day Year	3. Time of Death
н	Physicia /Medic		Sherman Willey		1	Vovembe		7 1245 PM
	Examin		4a. Facility Name (If not institution, give street and number)		Location of Death		4c. County of Death Dorcheste	
eri "d			Dorchester General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Cambrid		. Date of Birth		hplace (State or Foreign
н	Funeral Director		217-42-5483 1 M 2□F 65 Yrs.	Months Days	Hours Min. J	(Month, Day,) une 30,	(ear) 1944 Mary	yland
	σ		Usual Residence of Decedent					
	arylar show	'n	10a. State 10b. County 10c. City, Town or Loc Maryland Dorchester East Ne	w Market				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
1 _	28a-f	Directo	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Co	
2	3a or		6303 Snug Harbor Road	21631			USA	,
3	death	Funeral		Vas Decedent of H	ispanic Origin? (Speci an, Mexican, Puerto Ric	fy Yes or No-	14. Race - Ame Black, White	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. 3d other than "natural", or Items 23a or 28a-f show event, the Modral Exhibitor must be notified at	þ	1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No	□Yes 2XNo	Specify:	, o.o.,	· ·	White
2-0	72 hor	Completed	(Specify only highest grade completed) (Give	lent's Usual Occup	durina most of workina	16	Bb. Kind of Business/	Industry
2	/ithin ine. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	OO NOT use retired	1)		Seafood	
, D	illed w Hygie ther t	ပ္ပိ	11 Water 17. Father's Name (First, Middle, Last)	man	18. Mother's Name (#			
		To Be	Selvin Willey		Ethel Wro		,	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event,	-		g Address (Street	and Number or Rural P	Route Number,	City or Town, State, 2	Zip Code)
Σ	and 2 ealth a n 27 le				2, Secretai			
altimore,	ges 1 t of He If Iten or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crem				Oc. Location - City or	
ᆵ	t. Pag rtmen rtant: rjury	. 8	4 □ Donation 5 □ Other (Specify) Our Lady O.		msel 11/13,			
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.	92	21. Signs turn of Funeral Service Liceraee Zee	ller Fund 6 Main S	^{ss of Facility} eral Home, treet, East	P. O. I New Ma	Box 207 arket, MD	21631
			23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause a each line.	1 1		espiratory arres	st,	Approximate Interval Between Onset and Death
Sec.	Physician		Immediate Cause (Final disease or condition resulting in death)	ephalo	pathy			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	Ami +				
		- F	Sequentially list conditions, if any, leading to immediate b. Due to by as a consequence off:	,,()1				
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	7 tem	D15457	و		
0,	e exe ian ar urial-t	EX	resulting in death) Last Due to (or as a consequence of):	•		_		
68760,	ficate be executed physician and s the burial-transit	dical	d					
$\mathbf{\omega}$	leath certifi attending for use as	w	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of de	livery
. Box	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	1 Ves 2 No 4 Pregnant at time of death 5	Ectopic pregnand Other (specify) _	у		Month	Day Year
P.O.	at the de by the tached	hys	9 Unknown					
	res tha signed be det	by P	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause giv	en in Part I.			the cause of death?
ord	w require been si should t						2 □ No 3 2 P	robably 4 🗍 Unknown
Records,	e law has b je 2 st	Completed				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
a	Attending Physician: The Is redath. ector: After this certificate haby the funeral director, page 2		75. Who ages referred to medical		00 DI (D II (1 ☐ Yes 2	No 1 □Yes	2 🐪
5	rsicia s cert	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ npatient 2 ☐ ER/Outpatien	ot 3 D DOA Oth	26. Place of Death (er: 4 □ Nursing Home		nce 6 ☐ Other (Spe	ncihi)
o (ding Phy h. After thi funeral c	!⊱ .	27. Manner of Death 28a. Date of Injury 28b. Time of			-	v injury occurred	
jo	endin sath. or: Af he fur	atio	2 Accident investigation		Yes 2□No			
Division of Vital	i Sirte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)	eet, factory, office	28	f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the ti	me, date and place, ar	id due to the ca	use(s) and manner a	s stated.
	ne Hos ne Fur ne Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.					
	To the within 2 To the complet	ğ	29b. Signature and title of certifer	29c. Licens	e number	29	d. Date signed (Mont	th, Day, Year)
			My Vem Do	1 H51	793		11/9/00	7
			30 Name and address of person who completed cause of death (Item 23a) (Type,	Print)	hester Ar	. /	2101	ndix 100
	Sta	te.	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	1 Word	nes le 1tr	47011	El Camp	nicise MV
	Registr		31. Date filed (Month, Day, Year) NOV 12 2003 32. Registrar's Signature	alla				

DHMH 17 Rev 1/2001

Willey, Sherman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death Month Year 8:06 AM 2009 **Physician** NOV Jert Monzella /Medical c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 4801 Baltimore
If Under 1 Year | If Under 24 Hrs. St, air ane Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 1928 **Funeral** 1 □ M 2 🖫 F Months Days Hours Min 3-22-6718 31231 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Mydical Examinar must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number ò USA items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No 0 Specify. Black þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. Garment Industr resser is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 thur Johnson 19a. Informant's Name/Relationship (Type. Print) AFFILENA 20a. Method of Disposition Health a ti More Sonnier item 20g. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/09 HUrlock, MD. Veterans Cemetery : 22. Name and Address & Facility 4 ☐ Donation 5 ☐ Other (Specify) Henry Funeral Home, P.A. 510 washington St. Cambridge, MD. 21613 21. Signature of Funeral Service Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Alzheiner Immediate Cause (Final yeers **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural n 24 hours after death.
e Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 600er M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 408

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 009 38286 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1115am **Physician** 11)01 LOYI /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u>Anne Arundel</u> Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min. 0977271376 Months Days Hours Galesville,MD JM 2□ F 92 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD by Funeral Director Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21409 IISA 621 Edwards Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1▼1Yes 2□No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: WWII White 3√2 Widowed 4 □ Divorced "naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Shop Owner College (1-4or 5+) Elementary/Secondary (0-12) Barber of Health and Mental Hygie litem 27 is marked other I r other treumstic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Jacob Wolfe Mary Glazer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) of Health a Ronald Wolfe 689 Black Forest Road Annapolis, MD 21409 Son 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ŏ 11/16/2009 Annapolis,MD 21401 Kneseth Israel Cem. permit. Page Department of importent: if any injury or once. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12 Ridgely Ave Annapolis, MD 21401 0 Hardesty Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine iding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760 Physician/Medicai IF FEMALE use If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physicien: director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 Tyes 2 🗌 No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 Jennifer Ruddle-Frey 32. Registrar's State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Day Year November 4, 2009 **Physician** Richard Dudley Williams, Sr. 9:46 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery General Hospital **Onley** Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 11,1926 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min 83 Kentucky Director 336-20-6954 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evan from rough be notified at Director 1X Yes 2 □ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 International Drive; Apt. 761 20906 United States death v Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after XYes 2 No US Navy 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: Korean War Specify: Black 1 ☐ Yes 2 🛣 No ð Specify 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 n and Mental Hygiene. Federal Mediation and Associate Elementary/Secondary (0-12) College (1-4or 5+) Conciliation Service Federal Mediator/ Director years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Prince Edward Williams Elizabeth Jackson ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.0</u> of Health 27 Saundra E. Lincoln Lamb(Daughter) 814 Sheridan Street, N.W.; Washington, D.C. 20011 item 2 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov.17,2009 Department of Important: If if any injury or conce. 1 ☐ Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. Beltsville, Maryland nature uneral Ser 22 Name and Address of Facility R. N. Horton Company Morticians, Inc.: 600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arrhythmia disease or condition resulting in death) 1101R /Medical Due to (or as a consequence of): Examiner Cardiomypathy YEARS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence f) The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ģ Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performe 2 = No 2 PNo 1 ☐ Yes or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1☑Yes 2☐No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) M. D D0058770 November 04, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Graf, M.D. 18101 Prince

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

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, olny, MO

20832

Philip

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Warren Joseph Louis ovember Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's **Examiner** 4b. City, Town, or Location of Death Lanham Doctors Community Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1**x**x M 2 □ F Hours Min. June 19. 1928 81 Washington, 229-26-8006 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Prince George's Mitchellville 1 ☐ Yes 2xxxNo or 28a-1 Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20721 USA 3704 Clairton Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Korean ō Completed by 1 Never Married 2 Married 1XXYes If Yes, Give 1 ☐ Yes 2XX No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates. VV WITTEM JOSE Baltimore, Maryland 21215-00 permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Boys & Girls Club Executive Director vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles UNKNOWN Warren Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer L. Warren / Granddaughter 1917 Glendora Drive District Heights, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2xx Cremation 3 ☐ Removal from State 11/12/2009 Edgewater, Maryland 4 Donation 5 Other (Specify) Signatur f Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complicat θ s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one de se on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown peen FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy BLEED performed? FASTROINTEST 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of 🗪 tifier 29c. License number 552

State

Registrar

30. Name and address of person

31. Date filed (Month

GODDINCK ROAD

LANHAM

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** HELMA WHITE Nov 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Funeral Birthplace (State or Foreign Country) 1 □ M 2**X** F Months Days Hours Min Director 577-38-6751 87 July 1, 1922 Bowie, Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d, Inside City Limits ns 23a or 28a-f show must be notified at Director Maryland Prince Georges 1 X Yes 2 □ No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6305 Riggs Road; Apt. 102 20783 Completed by Funeral United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No **Black** Specify: 3 ☐ Widowed 4 X Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentary/Secondary (0-12) College (1-4or 5+) 12th grade the Domestic Worker Domestic Department of Health and Mental Hygin Important: If Item 27 Is marked other any Injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Hawkins Α. Florence M. Weldon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn T. Drakeford (Daughter) 14509 Livingston Road; Accokeek, Maryland 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 13, 2009 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify Mational Harmony Memorial Park Landover, Maryland 21 Signature of Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LETASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as attending p IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year ed by the a 5 Other (specify) P.O. vate nas been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ρ 4 Onknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2/2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannel of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 11 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR-5

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/06/09 1300 p Lenora M. Whiting 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George Fort Washington Fort Washington Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🖼 F Days Maryland 04/09/35 <u>579-46-1216</u> Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 □ No Maryland Prince George Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 United States 7002 Helen Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No **Black** Specify 3 ☐ Widowed 4 🖾 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Data Entry Operator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mamie Newman Roy Ransome 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald M. Whiting/ Son 2565 Oak Glen way Forestville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/14/09 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Washington National 21. Signal of Funeral Sorvice Linensee 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest shock, others failure. List only one cause on each line. Immediate Cause (Final ardin disease or condition resulting in death) Due to lar as a consequence of) Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MO Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? underlying cause given in Part I 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown autopsy

Physician /Medical Examiner

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page 2 should be

certificate

After this

24 hours after death. Funeral Director: #

funeral director,

filled in by

completely within 2.

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Department of Health and Mental Hygiene. I mus after to Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event.

Maryland 21215-0036

Baltimore,

death with the Maryland

Examiner Physician/Medical

þ

Completed

Be

Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No

25. Was case referred t

1∐Yes 2 No

examiner?

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

performe 1 ☐ Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🕱 No

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5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year) A

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a.	Certifier
	(Check onl
	one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11701

Registrar

OBIDRA GGB 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ₩ov. **Physician** 8, 2009 8:51 AM M MARIAN WOOD J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9-7-1942 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ■ M 2 1 F Months Days Hours OHTO 67 288-38-0258 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shore Examiner and Examiner must be notified at 1 Yes 2 □ No Director DISTRICT HEIGHTS PRINCE GEORGE'S 10e. Street and Number 10g. Citizen of What Country? U.S.A. 20747 3005 WALTERS LANE Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ≥ ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK "natural" Completed traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) EXECTIVE DIRECTOR COMM. MINISTRY P. G. YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of LENNIE ENGLISH WILKINSON CARL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9604 CONVERSE CT. BRANDYWINE, MD 20613 item 27 i RANI E. BROOKS - DAUGHTER 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 11-14-09 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. WASH., DC 20002-5236 524 - 8TH STREET, N. E. 23a. Part 1. Enter the disease, or complications that caused the death Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown мпет mis certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗖 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Natural 2 ☐ Accident Injury М 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examination On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certif

29c. License number

29d. Date signed (Month, Day, Year)

CLINTON, MD 20735

WENDELL PIERSON, M. D. 7503 SURRATTS ROAD

31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a&20b Maryland / Department of Health and Mental Hygiene

			For State Registrar		0.0.0		y land 7 D	Cer	rtificate of				Reg. No	2009	3	382	92
	Physici		Decedent's Name (First, Albert Har		wheele	r	, <u></u>					2. Date of De	eath Da	09 ^{Υe ε}	ar	3. Time of 1	Death
	/Medio		4a. Facility Name (If not inst	tution, giv	e street and no	ımber)			4b. City, Town, Chever1		ition of Death			. County of De			
	Funeral Director		5. Social Security Number 338–18–0262		Sex MΩM 2 □ F		In yrs. last birt	hday) 'rs.	If Under 1 Year Months Days	r If U	ours Min.	8. Date of Bi (Month, D 09-11-	rth 1922	9. E Was	Birthpla Countr Sh.	DC	Foreign
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1	n with the	Funeral Director	10e. Street and Number 1513 Jutewood	Ave	•				10f. Zip Code 20	785			10g. Ci	tizen of What	Countr	y?	
000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Infinortant: If filed IZ is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Examinar must be notified at once.	by	11. Marital Status 1 □ Never Married 2 🔀 3 □ Widowed 4 □ Div		12. Was Dec Armed F 1 XYes If Yes, G Year or I	orces? 2 No ive	er in U.S.		Vas Decedent of f Yes, specify Cu I □ Yes 2 No		ic Origin? (Spexican, Puerto ecity:	Puerto Rican, etc.)			merica hite, et lac		
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ב, יום	l and 2 st Health an Im 27 is r Iher traur		Healphormant's Name/Rela	/ Wi	fe 		151	3 3	g Address (Stree Jutewood	Ave	e. Land	dover,	MD 2	0785			
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	/Medical Examiner			1	Due to		onsequence o	f):									
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	n 24 hours after death. Part of the sector	Certification:	4 ☐ Homicide d	etermined	build	ling, etc. (tc. (Specify)				28f. Location City or To	wn, State	e)			oer,	
Hoen Too	within 24 hour To the Fune Completely fi	edical	29a. Certifier 1 🔀 Cer (Check only 2 🗆 Mer	tifying Pi lical Exa	miner: On the	e best of r basis of ex oner stated	kamination and	death dor inv	n occurred at the vestigation, in my	time, da opinior	ate and place n, death occu	, and due to the rred at the time	e cause(s , date an	s) and manne d place, and	r as sta due to t	ated. the cause(s)	,
1	with To t	Σ	29b. Signature and title of co	rtifier	G. S.	wap	na.		29c. Licer	ose num	100	4)	29d. Da	ate signed (Mo	onth, D	09 ·	
ا ا	5		30. Name and address of pe	rson who				Туре, І	Print) Bod 1	rbos	pital.	Drue	Cha	verly, A	S	207	85
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 11 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7.00AM Edgar T. Arold, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore-Washington Med. Ctr Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F (Month, Day, Year) Maryland 87 Director 213-12-0915 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Anne Arundel Glen Burnie 1 Yes 2 XNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1206 Oakwood Road 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc Completed by Tanever Married 2 Married Maryland 2121510036 1 ☐ Yes 2 No Specify. White Specify. 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Foreman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Arold Violet unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Edgar T. Arold, Jr. 14016 Castaway Drive, Rockville, Maryland 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 12/2/2009 Elkridge, Maryland oxaty of Funeral Service Licen 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Ratenia po Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav sate has been signed by the a page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying causagiven in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 2 No မ 1 🔁 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Accident 24 hours after deat e Funeral Director; Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09

State Registrar 31. Date filed (Month, Day, Year)

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MJ2106

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

RWMC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 38294 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15:45 PM **Physician** William banks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 21239 Baltimore City Samaritan Hosp.tal 500d If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1**X** M 2□ F 7. Age (In yrs. last birthday) Year) **Funeral** Hours Months Days 217-38-3945 MARYLAND 7/28/1940 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Exponing rounts be notified at 1 ☐ Yes 2 No Director BALTIMORE RANDAILS TOWN MD. 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 21133 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Comcast Elementary/Secondary (0-12) College (1-4or 5+) BECURITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BANKS HARVE DOBSON ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2//33 19a. Informant's Name/Relationship (Type, Print) SPRING DALE AVE. RANDAILS FOUN, MARYIAND RENEE R. BANKS WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition THE DERRICK C. JONES FIH, P.A. 2,1215 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens 4611 PARK HOTS. AUE. BALTIMORE MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stage cardio myo pathy End years **Physician** /Medical Due to (or as a consequence of): Examiner disease years Coronaly all Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Jear Hypertens on Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 2 🗆 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation 1 V Natural n 24 hours after death. te Funeral Director; Aff bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 04965145

State Registrar Olga

Julye,

MD

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Battimore.

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year NOVEMBER MILDRED 4:40 AM 26 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltu (0 MANUR CARE TUWSON Towson Balto If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 2-18-1936 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2🛣 F 73 213-34-1702 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exercitive Invest be rotified at aprile. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1510 N. Patterson Park Avenue S 21213 Α Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify \$ Specify: Black Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 6th grade College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Smith Leo Canady ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 804 E. 35th Street Balto, MD 21212 David Canady-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 12-4-2009 Lansdown, MD Μt March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 la LA ano 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease of Injeny that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 PNo been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð DECURITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D57722 NOVEMBER 30 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TREE ROAD #300 AILESVILLE MD 21208 LEUNARD RICHARDSON M.D. 1838 GREENE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da 11/30/2009 **Physician** Cornelius P. Bleyer 1600 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 061-20-4092 82 3/3/1927 Director Austria Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: if the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Nedica Examine must be molified as MD Harford Forest Hill 1 ☐ Yes 2 ▼ No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1717 Landmark Drive Unit J 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xfves 2 □ No If Yes, Give Year or Dates: 1944-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 Never Married XX Married 1 ☐ Yes 2 🕱 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Account Exec. Advertisement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dr. Leo Blever ပ္ Franziska Juda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1717 Landmark Drive Unit J Forest Hill, MD 21050 e of Disposition (Name of Date 20c. Location - City or Town, State Eileen Bleyer/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. 12/9/2009 Owings Mills, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Part 1. Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as e consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed and the attending physician ned for use as the buria P.O. Box 68760 is certificate has been signed by the director, page 2 should be detached Division of Vital Records, To the Hospital or Augustin 24 hours after death.

To the Funeral Director: After this or annual place in by the funeral director.

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

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Sta	te

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
DEC 0 2 2009

address of person who completed cause

DHMH 17 Rev 1/2001

and manner stated.

Signatur

your.

🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Em Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? [] [] 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** М Margaret Roberta Butts 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ELAIRHERIHAND BEHABILITATION CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day 2 (Sear) 191 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Country) 217-22-7745 1 □ M 2 😾 F 96 3 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination to notified all MD Baltimore Essex 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 314 Long Cove Lane 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. 1 □Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: þ 3₺ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Peltzer Elementary/Secondary (0-12) College (1-4or 5+) Sport Shop 12th Office Clerk permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If Item 27 is marked other I any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Haines Edna Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 949 LAke Clear Road Eganville Ontario Robert Peltzer/grandson Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Gardens of Faith Rossville MD 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/4/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Fineral Service Licentellanie Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart **Physician** Congestive disease or condition resulting in death) /Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-tran Due to (or as a consequence of): 68760 pe Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 19 months? Month Day Year 5 Other (specify) ed by the a detached f P.O. 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð ▼ No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No eertificate has b irector, page 2 sh 24a. Was an autopsy 1 □Yes 2 of Vital director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Division To the Hospital or Attending within 24 hours after death. 1 Natural within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of ce tifier December 1, 2009 MD 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) Revolution St. Havre de Grace, MD 21078 Benjamin Y. Lee MD 669 31. Date filed (Month, Day, Year) State Registrar

completely

State Registrar

31. Date filed (Month, Day, Year) DEC 02

(Check only

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number RES-001 29d. Date signed (Month, Day, Year)

NOVEMBER 30, 2009

09-09226 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Matthew Keith Buckler State of Maryland / Department of Health and Mental Hygiene <u>2009 3829</u>9 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 27, 2009 Matthew Keith Buckler **Medical Examiner** 1425 hrs 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death 3115 Orchard Avenue Parkville **Baltimore County** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Country) 215-21-9737 Director Months Davs Hours 1X M 2 Aug. 28, 1988 Yrs MD Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Parkville 23a or 28a-f show 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 3115 Orchard Avenue 21234 USA Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 X Never Married 2 Armed Forces? White etc Married 1 X Yes Widowed Divorced If Yes. Give Yea Yes 2 X No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) the Medical Soldier Baltimore, MD 21215-0036 Army 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Joseph J. Buckler Be Michelle Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Joseph Buckler / father 2451 Old Forge Road Broque PA 17309 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Bayview Crematory Department o 11/30/09 Baltimore MD Other Specify Donation 5 21. Signature of Funeral Service Li Anse 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part I. Enter the disease, or complications that capsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease Heroin intoxication **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED physician the burial AMENDED 23a,27,28a-f,permE, g898 12/10/09 TT Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 1 🗸 Yes 2 No

The law requires that the death certificate be Records, P.O. certificate ysician: Vital æ T₀ Certification: Medical

Division of	To the Hospital or Attending P	within 24 hours after death.	To the Funeral Director: After
		/	

Carol Allan, MD Assistant Medical Examiner 31. Date filed (Martin Pay (e.) State

29b. Signature and title of certifie

25. Was case referred to medica

No

Pending

6 X Could not be

Investigation

examiner?

2

3

1 Yes

27. Manner of Death

Natural

Accident

Suicide

Homicide 29a. Certifier 1

> 111 Penn Street, Baltimore, MD 21201 egistrar's Signatur

Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated

au

Fd 11/27/09

ER/Outpatient 3

28b. Time of Injury

Fd 2:21

28e. Place of Injury - At home, farm, street, factory, office building, etc

residence

26.Place of Death (Check only one)

unk

Nursing Home 5 Residence 6 Other: Scene

28f. Location (Street and Number or Rural Route Number, City

November 28, 2009

29d. Date signed (Month, Day, Year)

or Town, State) 3115 Orchard Ave

28d. Describe how injury occurred

Other₄

Yes 2X No

28c. Injury at Work?

29c. License number

O.C.M.E.

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registra

30. Name and address of person who completed cause of death (Item 23a)

Hospital: ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedept's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 45P M 2 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner BALLIMORE Ltimore CENTER N/AIf Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Months Days 1 X M 2 □ F MARYLAND Director 219-32-9232 71 6-24-1938 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location tiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to notified at 1 □ Wes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4216 RIDGEWOOD AVE. 21215 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12-MORTICIAN FUNERAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental I em 27 is marked of Pages 1 and 2 should be JOSEPH BAILEY GWENDOLYN HOLLAND 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CONSTANCE BAIDEY (WIFE) 4216 RIDGEWOOD AVE. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12-1-2009 permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State GARRISON FOREST VETERANS OWINGS MILLS, MARYLAND 21. Signature of June of Service (cense JONATHA) D. HIBN R22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARŶLAND 21217 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme in e Cause (Final diserts or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** hosi-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). or Attending Physiclan: The law requires that the death certificate be executed Exam signed by the attending physician and I be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 4 Pregnant at time of death ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe iours after death.

neral Director: After this certificate | filled in by the funeral director, page 1 □Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-23 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 NORTH GREENE STREET BALT MORE MD 21201 MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

09-09018 Steven Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	IBIOWII		State of Maryland / Departr 1- For State Certifi Registrar	icate of Dea		Reg.	200	19 3830						
	Physicia	an/	Decedent's Name (First, Middle,Last)			2. Date of Death Month Daniel November 2	ay Year	3. Time of Death 1124 hrs						
edic	al Exami	ner	STEVEN BROWN 4a. Facility Name (if not institution, give street and number)	4b. Cit	y, Town, or Location of De		4c. County of Death							
			Franklin Square Hospital	1	sedale	Baltimore County								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to		Inder 1 Year If Under 24	Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Bir 965 Foreig	thplace (State or						
	Director		091-62-4142 1X M 2 F 44	Yrs.	ntris Days Hours	5-2- 1	967 co	ountry)NEW YORK						
	á		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tox	wn or Location				10d. Inside City Limits						
	nd how a	_	MD. N/A BAL	TIMORE				1 X Yes 2 No						
	farylar 28a-f s Lat on	Director	10e. Street and Number	10f.	Zip Code	10g.	Citizen of What Cou	ntry?						
	h the N 3a or otified		4313 BELVIEU AVE		21215		USA							
	ath wit tems 2 st be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?		edent of Hispanic Origin? ecify Cuban, Mexican, Pu		14. Race - Amer White, etc.	rican Indian, Black,						
	fter de: ", or i er mu		1 Yes 2 A No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes	2 No specify:		Specify: BL	ACK						
	ours a	ed by	(a) 2	Sa. Decedent's Us	ual Occupation (Give kind working life. DO NOT use		6b. Kind of Business	/Industry						
36	in 72 l han "r Jical E	plet	Elementary/Secondary (0-12)				CADITAL	CDDTNUI EDC						
00-	d with ygiene other t	Completed	17. Father's Name (First, Middle, Last)	DRIVER		ame (First, Middle, Mai		SPRINKLERS						
21215-0036	hould be filed within 72 hours after and Mental Hygiene. is marked other than "natural", atic event, the Medical Examiner	Be	MOSES BROWN		GL.	ORIA J. TH	OMAS							
D 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland bepartment of Realth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>	ဠ	19a. Informant's Name/Relationship (Type, Print) VICTORIA BROWN (WIFE)	19b. Mailing Addr 4313 E	ress (Street and Number BELVIEU AVE.	or Rural Route Number BALTIMORE	er, City or Town, Stat MARYLANI	e, Zip Code) D 21215						
MD	and 2 Tealth Item 2 traum				Name of cemetery,	Date	20c. Location - City o	r Town, State						
nor	ages lent of F		1 22 Buildi 2 Coemation 3 Nemoval from state	matory or other pla		1-25-2009	RATITIMORE	MARYT.AND						
Baltimore.	rmit. F spartme porta		21. Signature Tuneral Service Licensee JONATHAN D. HI	BN R. Name	and Address of Facility P	HILLIPS FU		ME, P.A.						
_			23a. Part I. Enter the disease, or complications that caused the death. Do	1721-	-27 N. MONRO	E ST. BALT	IMORE MAI	RYLAND 21217 Approximate Interval						
	hysician /Medical		faflure. List only one cause on each line.				,	Between Onset and Death						
	caminer		Immediate Cause (Final disease or condition resulting in death) a.ATRETOSCIETOTIC Due to (or as a consequence of):	Cardiov	ascular ulse	ase								
		يا اير	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
		Examiner	cause. Enter Underlying Cause											
	ted 1 ansit	Exa	events resulting in death) Last Due to (or as a consequence of):											
	e execu sian and ial - tra	Medical	Xunpended Xamended 23a, 27, po	FH g899 erME, G8	1/6/10 TT 98 12/10/09	ТТ								
760		/Me	IF FEMALE: 23c. If yes, outcome of pregnar	ncy			23d. Date of delive							
Box 687	that the death certificated by the attending for the detached for use as the	Physician/	past 12 months? 4 Pregnant at time of death	2 Fetal de		egnancy	Month	Day Year						
B		hysi	1 Yes 2 No 9 Unknown 9 Unknown			Logo Did tob	and the contribute of	to the cause of death?						
C	The law requires that the cate has been signed by the page 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resu	alting in the under	lying cause given in Part I			obably 4 Unknown						
	equires een sig ould be					24a. Was ar		autopsy findings available						
j	certificate has been ector, page 2 should	Completed				autopsy perform	ned? death?							
Ä		e Co	25. Was case referred to medical		26.Place of Death (Ch									
Division of Vital Records	hysicia this ce I direc	O B	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V El				tesidence 6 Oth	ner:						
9	ding Ph	on: T	1 X Notural (Month, Day, Year)	8b. Time of Injury	28c. Injury at Work?		ow injury occurred							
į	or Attend after death Director:	cati	2 Accident Investigation 28e. Place of Injury - At hom	ne. farm, street, fac	11.		reet and Number or	Rural Route Number, City						
į	Hospital or Attending Physician: 44 hours after death Funeral Director: After this certificity filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined (Specify)	,		or Town, Sta	ate)							
	E Hospital 124 hours e Funeral etely filled													
	To the Hos within 24 h To the Fur completely	Medical	and manner stated	i/or investigation, i	in my opinion, death occur	red at the time, date a	29d. Date signed (A							
	_	≥	29b. Signature and title of certifier	50	O.C.M.E.		November 21,							
J	0		30. Name and address of person who completed cause of death (Item 2:	3a)										
R	V		Victor Weedn MD JD Assistant Medical Examine	er 111 Penr	n Street, Baltimore,	MD 21201		<u> </u>						
	S	tate	31. Date filed (Month, Day Year) 32. Jegistrar's Signature	South	2.0									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38302 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Angelo (ae Sar :30 PM Michael 3 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE E. HOFFMAN If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months 3 3 MARVIAND **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 ☐ No BALTIMORE MD. 10e. Street and Numbe 10g. Citizen of What Country? Funeral 4.5,A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NONE NONE <u>L2</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname th and Mental H ည ANGELO CAESAR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 12/5 19a. Informant's Name/Relationship (Type, Print) St. 1 and 2 s of Health item 27 CAESAR MOTHER VINE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/2009 DERRICK C. JONES FIH. CREMATOR 4 ☐ Donation 5 ☐ Other (Specify) Singlure of Funeral Service Lie 4611 PARK HGTS. AVE. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pena 1 Diseast Immediate Cause (Final thd-Stale Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a ld be detached fo Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Division of Vital Records, within 24 hours after death.

To the Funeral Director. After this certificate has been sit completed filled in by the funeral director, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death.
 Funeral Director: After this certificate has b. performed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 🗆 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 W Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 12/2/09 000574

DHMH 17 Rev 7/2009

2

State Registrar Main

Juite

Reisterstown, MD. 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

5. Rajapa Kse

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1605 P WILLIAM CULLISIA VOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOHNS HOPKING BAYVIEW MEDICAL CENTER BALTIMORE 7. Age (In yrs. last birthday) 84 Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Februs 1925 Pear 1925 Mary Land 216-20-0300 1 🛛 M 2 🗆 F Days Hours Min Director Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County 10a. State 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21224 7751 Eastdale Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces?

1X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced ier than "natura t, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M College (1-4 or 5+) Elementary/Seconday (0-12) General Electric Transformer Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sophie M. Dibbern ည William T. Cullison ____ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7751 Eastdale Road Baltimore, MD 21224 Elsie Cullison/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dak Lawn Cemetery 12/04/09 Baltimore, 22. Name and Address of Facility 300 Mace Connelly Funeral Home Avenue Balto, MD of Essex 21221 f Funeral Survice Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CHOKING Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner FOOD BOLUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) EFFIFICATION APPROVED BY WESTCHLEENWER DEMENTIA 15 YEARS ALZHEIMER'S attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed this certificate 1 Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident iniury 5 Pending work? 1 ☐ Yes 2 💢 No subject choked on food death. 11-23-04 Investigation C9:00 AM 24 hours after deatle Funeral Director: 6 Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 775 | East441 Rd filled in by determined At home Baltimore MD Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature_and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2ES-001 ario NOVEMBER 30, 2009 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYARET CAVANANGH-THISEY, MD. 4940 EASTERN AVENUE, BALTIMORE, MD. 21224 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

DEC 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month Day **Physician** Kever 2.009 November ameror /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XX Days 212-48-5256 63 4, PA Dec. 1945 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1∏Yes 2∏No Director MD Prince George's be notified Laurel 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 1054 Marton Street 20707 U.S.A. Funeral Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify Specify: <u>ک</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education traumatic event, the Medical (Specify only highest grade completed) Grade 12 College (1-4 or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Garner Velma McClincv မ and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert S. Cameron / Department of Health Important: If item 27 any Injury or other tra spouse 1054 Marton Street Laurel, Maryland 20707 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) W.Arundel Crematory | 11/25/2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland <u> 20707</u> Approximate Interval Between 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final SMA II Due to (or as **Physician** cell disease or condition resulting in death) cance /Medical a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown 5 Other (specify) Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ Division of Vital Records, 1 Yes 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1 X Inpatient 2 ER/Outpatient 3 DOA 1 Yes 5 Residence 6 Other (Specify) ၉ the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury Pending 1 Tyes 2 □ No after death. investigation Accident Could not be 3 Suícide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 - Homicide 24 hours a the Hospital 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30 N

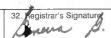
31. Date filed (Month, Day, Year) 2009

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dress of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nonth NOV **Physician** 200 /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pikesville Baltimore courtland Gardens Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F Maryland Director ual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 Komaric ourt, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MTA Mechanio 12th grade vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 Romaric Court, Apt. F Marcella Davis Baltimore MD 21209 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD Greenmount Crematory 12/03/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Acility J. Greene Funeral SUCS Jaughn Road Randall Stown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 6 month enten & Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onsequence of): Due to (or as a) Examiner burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician pe Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 Probably page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed? certificate ! 1☐ Yes Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the letely filled in by the funeral Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30 Name and address of derson who completed cause of death (Item 23a) (Type, Print)

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Amend #17, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 38306 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lorraine Margaret Dugger 26 2009 00:06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, 1 1 □ M 2**y**□ F Months 219-14-2494 Yrs Director 86 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD NA Baltimore 1X Yes 2 □ No 10e. Street and Number 6 10f. Zip Code 10q. Citizen of What Country? items 23a Funeral 21211 3855 Greenspring Ave Unit 209 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Black "natural", Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade 5yrs+ Teacher Schools Be 17. Father's Name (First, Middle, Last)
Charles Whyte permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or cer. 18. Mother's Name (First, Middle, Maiden Surname) Bertina Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Dugger Jr.-Son 904 Dartmouth Road, Baltimore, Md 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 12/4/09 Dulaney, Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lie March FTH West 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hronic bstr. Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner It any, reading to minisolate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for ea a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and -trans resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year a | Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy page certificate 1 Yes 2 No 2 💆 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 KNo Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No Accident Investigation within 24 hours after death

To the Funeral Director; completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certi 29c. License number 29d. Date signed (Month, Day, Year) D68104 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tricBust 211-Pe 4105 6701-N.Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Physic		1. Decedent's Name (First, Middle, Last)	F	rman	2. Date of Death	Day Year	3. Time of Death
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with the a or 28 be noti	Director	10e. Street and Number		10f. Zip-Code	100	g. Citizen of What Cor	•
yland 21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. Area other than "natural", or items 23a or 28a-f show after event, the Medical Examiner must be notified at	by Funeral	10404 Barretts Delight D 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates:	in U.S. 13.	Use 21030 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 ▼ No Specify:	(Specify Yes or No- erto Rican, etc.)	U • S • A 14. Race - Amer Black, White Specify:	rican Indian,
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	10205 20b. Place of Dispo cemetery, crem ake Vie	natory or other place)	ace Apt Date 20 /28/09 S	H, Cocke Oc. Location - City or ykesvill	ysville, Md Town, State e, Md
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DIVISIC pltal or Attend ours after death eral Director: A	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (Sp.	pecify)		City or Town,		
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To the Hosp within 24 ho To the Fune completely f	Me	29b. Signature and title of certifier		29c. License number RES 000	290	d. Date signed (Month	R 25, 2009
		30. Name and address of person who completed cause of death WICKRAMASINGHE, PAS	(Item 23a) (Type,) North Wolfe	e St. Raltime	ore, MD, 21287
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's S	ignature	Seid !	7101111 11011	· ·	, 11.0, 21201

DHMH 17 Rev 1/2001

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Robert Joseph Edo	1-	ton State of Maryl	and / Department of Certificate of			ntal Hyg		. N o.	200	9	3830
Physician	/ 1	. Decedent's Name (First, Middle,Last)					. Date of Death Month November :	Day Onco	Year		of Death 0 hrs
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Funeral Director		. Social Security Number 6. Sex 1226~19~7217 1X M 2 F	7. Age (In yrs. last birthday) 59 Yrs.	If Under Months	r 1 Year If Und		8. Date of Birth	,	Foreig	in _	_{State or} nada
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland in the Tis marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		Mever Married 2 Married 1 Yes XX Widowed 4 Divorced If Yes, Give Yer or Parter:	Forces? If You are the second of the second	es, specify Yes 2x		n, Puerto R	ican, etc.)	Spec	my.	hite	
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MD 21215-0036 d 2 should be filed within 7 lift and Marual Hygiens in 27 is marked other than numatic event, the Medical To Be Comput	2 1	9a. Informant's Name/Relationship (Type, Print) Nancy Peth (Personal Re	ep) 701 (Quain	(Street and Nu It Acres	Driv	e Silv	er Sp	ring,	Md.	20904
Baltimore, permit. Pages I an Oepartment of Heal Important: If iten injury or other tra	2	0a. Method of Disposition Burial 2x Cremation 3 Removal 1 Donation 5 Other Specify:	20b. Place of Dispos from State crematory or oth Metro Crema	er place)					tion - City or LMOre,		state
Baltimo permit. Page Department o Important: injury or ott	ŀ	1. Signature of Funeral Service Licensee	i 74	01 Be	Address of Facili n Finera elair Ro	d. Bal	ltimore	, Md.	21236		
Physician /Medical xaminer			lunt Force Injuries	ne mode o	f dying, such as	cardiac or i	respiratory arre	st, shock, o	r heart		oximate Interval een Onset and Death
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the today of the complete of the physician of the complete of the physician of the complete of the physician of the complete of the control of the c	nilbiere						24a. Was a autops perform	y	prior to death?		ndings available on of cause of
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Division or spital or Attending nours after death cours in the course of the filled in by the functions of the filled in by the functions of t		Suicide Could not be determined (Specification of Specification)	ace of Injury - At home, farm, stree Major Road / Highway	-	, office building,	etc.	28f. Location (S or Town, Si lotchcliffe Rd	treet and N ate) & Glen A	rm Rd, Gle	ural Rou en Arm,	te Number, City Md.
Division of Vital Brother To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		ne) 2 Medical Examiner:On the basis	est of my knowledge, death occur s of examination and/or investigat stated.	ion, in my	opinion, death o	occurred at	due to the cause the time, date a	ind place, a	and due to th	he cause	
	٤ ²	9b. Signature and title of certifier	SMP	290	O.C.M.E.	er			signed (Mo		/, Year)
5			Medical Examiner 111	Penn S	Street, Baltin	nore, MD	21201				
Stat Registra		1. Date filed (Month, Day, Year)	Registrar's Signature	enter	0						
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State of Maryland / Department of Health and Mental Hygiene

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Physician	
/Medical	
Evaminer	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marketal Examinar must be rediffed at any injury or other traumatic event, the Marketal Examinar must be rediffed at any injury or other traumatic event, the Marketal Examinar must be rediffed at any once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Sta Registr

•	1 - State Registrar	Cer	tificate of	Death		Reg. No	2009	38309	
	1. Decedent's Name (First, Middle, Last)				2. Date of Do Month	eath Da	y Year	3. Time of Death	
n	Ronald Jackson Frady				Novemb			6:30 A M	
r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Dea	th	4c	. County of Death	1	
	5003 Morning Star Drive		Day If Under 1 Year	ton	Doto of Di	wtla	Howard	nplace (State or Foreign	
	5. Social Security Number 6. Sex 7. Age (In yrs. Ia 1 ☑ M 2 ☐ F	(St Dirthday) Yrs.	Months Days	Hours Min	. (Month, D	ay, Year)	Cou	th Carolina	
	451-60-9013 67 Usual Residence of Decedent				03-08	-194	Z NOIL	II Calullia	
		Town or Loc	ation		-			10d. Inside City Limits	
jo	MD Howard		Da	yton				1 □Yes 2 XNo	
irec	10e. Street and Number		10f. Zip Code		-	10g. Ci	itizen of What Cou	untry?	
a a	5003 Morning Star Drive		21	036		Un:	ited Sta	tes	
Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	i. 13. V	Vas Decedent of H	lispanic Origin? (an. Mexican, Pue	Specify Yes or N	0-	14. Race - Amer Black, White		
	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give		□Yes 2XINo	Specify:			Specify:		
g Di	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	160 Doord	lent's Usual Occup	ention		16b k	Wh Kind of Business/l	ite	
Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give I	kind of work done OO NOT use retire	durina most of wo	orking	TOD. 1	And of Business/i	nadotty	
E O	Elementary/Secondary (0-12) College (1-4or 5+)		Soldier			Un	ited Sta	tes Army	
Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middl	e, Maidei	n Surname)		
0	Kelly Frady			The1	ma Jack	son			
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or F	Rural Route Num	ber, City	or Town, State, Z	ip Code)	
	Renate Frady / Wife	5003	Morning_	Star Dri	ve Dayt				
	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	ace of Dispos metery, crem	sition (Name of natory or other plac	ce)	Date	20c. L	ocation - City or	Town, State	
		Arunde	1 Cremat	ory 12-0	2-2009	0d	enton, M	aryland	
	21. Signame by Funeral Service License	22	Name and Addre Donaldso 1411 Ann	ss of Facility n Funera anolis R	1 Home	& Cr	ematory, Maryla	P.A.	
	23a. Rart J. Ehter the disease, or complications that daused the death.			_			, 1102) 10	Approximate Interval Between	
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Metastatic	2000	11 -011	140-			Onset and Death		
	disease or condition resulting in death) a. IICT 4.5TAT1C Due to (or as a consequence)	ence of):	nall cell	10,19			S MORING		
	On a constitution and state of the same state of								
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):							
Examiner	Cause (Disease or injury that initiated events c	ence of):							
E E	Due to for as a consequ	C1100 017.							
Medical	d								
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant						ivery		
Completed by Physician/	in the past 12 months?		Ectopic pregnand Other <i>(specify)</i> _	су 			Month	Day Year	
hys	9 Unknown								
S P	Part II. Other significant conditions contributing to death but not resu	lting in the ur	nderlying cause giv	en in Part I.				the cause of death?	
ted					- 17	Yes	2 □ No 3 □ Pr	obably 4 🗌 Unknown	
ple					24a. Wa	opsy	prior to o	topsy findings available completion of cause of	
S					per 1 □ Yes	formed? 2 X N	death? lo 1 □ Yes	2 🗆 No	
Be	25. Was case referred to medical examiner?		Ott	or.	eath (Check only				
9	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Inpatient 2 ☐ I 27. Manner of Death	ER/Outpatien 28b. Time of		- TI Haraning	Home 5 Re		6 ☐ Other (Spe	cify)	
ţion	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	Injury	Wo	ḱ? lYes 2 □No					
fica	3 Suicide 6 Could not be 28e. Place of Injury - At hor	me, farm, stre	eet, factory, office		28f. Location	(Street a	and Number or Ru	ural Route Number,	
Serti	4 ☐ Homicide determined building, etc. (Specify	')			City or T	òwn, Sta	(e)		
27. Manner of Death 28a. Date of Injury 28b. Time of Injury									
ledi	one) and manner stated.		29c. Licen						
_	29b. Signature and title of certifier Michael R. G-ll	10		se number 25 - 00	November 28, 2009				
		22a) (T			1 010/1001 20, 200				
	30. Name and address of person who completed cause of death (Item Michael R. Grunwald ECO North		Street	Baltimor	e, MD	217	287		
e	31. Date (iled (Month, Day Year) 32. Registrar's Signat	ure							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. 2 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29 AUREEN M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 9515 Snead Court Laurel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours 1 M 2 Washington, DC 87 Director 578-22-2839 Mav Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's 1 Yes 2 X No Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9515 Snead Court 20708 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Ø Bookkeeper Hotel Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isabella Donaghey Frederick Joseph Kloetzli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peratino/Daughter Narrows Lane, Bowie, MD Maureen 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 12/1/2009 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home M01103 313 Talbott Avenue, Laurel, ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Part 1 Enjer the disease, or compleshock of heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence of if any, leading to mineutate cause. Enter Underlying Cause (Disease or iinjury that initiated events ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown for Pregnant at time of death Month Day Year 5 Other (specify) detached within 24 hours after death.

To the Funeral Director, After this certificate has been signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ၉ 1 🗌 Yes 2 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 \square Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one)

31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

HATEL

un

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28f, per ME 8898 12/17/09 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Fleischer NOV 2009 1720 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number 6. 6ex. 7. Age (In vrs. last birth 8. Date of Birth (Month, Day, Feb. 17, If Under 1 Year | If Under 24 Hrs. 6. 6ex 1 XM 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Maryland Director 215-88-2612 37 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Accomack Horntown Virginia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a or 192 Limpet Drive 23395 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event. The Mea Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ae James Russell Fleischer Mary Linda Christian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Fleischer / Mother 3206 Seiter Lane, Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 11/16/09 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the spease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear salure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (of as a consequence of): **Physician** /Medical Examiner Duen 008 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CENTERCATION APPROVED BY MENCAL EXAMINES Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month yes 2 □ No 9 □ Unknown Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Division of Vital 1 ☐ Yes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Impatient Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending 1 🗌 Natural 5 Pending 1 ☐ Yes 2 No -2009 investigation ubject ing 2 Accident Director; 6 Could not be determined 3 Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number 109/2r Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as styled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 hours a Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 1598967499 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COX S Greene

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

0 2 20

32. Registrar Signature

84.

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:20 p Physician/ Nov 28, 2009 Year Mary Fuller Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2**X**□ F Months Days Hours Couldaryland Manth 18, 1925 Director 84 217-22-8108 Jsual Residence of Decedent 3a or 28a-f show be notified at 10b. County 10c, City, Town or Location death with the Maryland Director 10d. Inside City Limits X 1 Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. ?7 is marked other than "natural", or items 23: traumatic event, the Medi al Ex. miner must l 21225 3027 Larue Square 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. and 2 should be filed within 72 hours after c Health and Mental Hygiene. em 27 is marked other than "natural". or i 1 Never Married 2 Married Black 1 ☐ Yes 2 🗷 No Specify: 3 X Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Social Security Administration College (1-4 or 5+) Government Employee Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Florence Middleton William Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3027 Larue Square Baltimore, Maryland 21225 permit. Page 1 and Department of Healt. Important: If item 27 any injury or or Veronica Carter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖫 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗆 Donation 5 🗀 Other (Specify) Laurel, Maryland 12/05/09 Maryland National Park Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Er for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause heach line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral inversion and sompleted filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or linjur) that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 🗌 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title, of 29c. License number 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JONES,

CRNP

JACKIE

31. Date filed (Month, Day, Year)

р.ш.

DHMH 17 Rev 7/2009

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 6;30P M BERNARD FLYTHE NOVEMBER 25, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6762 REAL PRINCESS LANE WOODLAWN BALTIMORE

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, it a Modified Event with the modified at once. Baltimore, Maryland 21215-0036

Physician

Examiner

Funeral Director

/Medical

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State

31. Date filed (Month, Day, Year)

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	5. Social Security N		6. Sexy 1 ☐ M 2 ☐ F	7. Age (in yrs.	iast birthday) Yrs.	Months Days		Min.	(Month, D	ay, Year	r)	Country)	(State or Fore	egn
	225-68 Usual Residence of			61					11-12-	1948	3 V	IRGIN	IA	
	10a. State	10b. County	,	10c. Cit	ty, Town or Lo	ocation				10d. I	nside City Lim	its		
ō													1∭Yes 2∐I	No
ec ec	MD • 10e. Street and Nur		IMORE		WOODLA	N 10f. Zip Code				10- 0	itizen of Wh	at Country?		
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Funeral Director	6762 R	EAL PR	RINCESS LA			2120					JSA			
Ĕ	11. Marital Status		Armed Fe	edent Ever in U. orces?	.S. 13.	Was Decedent of If Yes, specity Cu	Hispanic Or ban, Mexica	rigin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	0-		American II White, etc.	ndian,	
by F	1 Never Marri		l If Yes. G	2 □ No ive		1 □ Yes 2 □ No	Specify	:			Specify:	BLACK		
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to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)														
o JESSE FLYTHE MARIE PORTER														
	19a. Informant's Na				T	ng Address (Stree								
	DONNA	R/ CLA	RK+FLYTHE	(WIFE)	676	2 REAL P	RINCES	SS LA	NE BAL	TIMO	DRE, M	ARYLAI	ND 2120	7
	20a. Method of Disp			20b. F	Place of Dispo	osition (Name of matory or other pl	ace)	12-2	ate -2009	20c. l	Location - C	ity or Town,	State	
	1 🗗 Burial 2 4 ☐ Donation			State		FOREST V	i			NW TN	IGS MT	T.T.S. N	1ARYLAN	(D)
	21. Signature of	ineral Servige	Licens ONAT										211(11411)	_
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	23a. Prt1. Inter t	he disease, o	r complications that	caused the deat								Apr	oroximate	
	hock or hea	irt failure. List	t only one cause on	each line.		.00							erval Between set and Death	
	Immediate/fause (disease or condition resulting/indeath)	n	a.	olon		cer								
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<u>=</u>	Sequentially list cor if any, leading to im cause. Enter Unde	mediate rlying	Due to	(or as a conseq	uence ot):									
Examiner	that initiated events resulting in death) I		C	(or as a conseq	uanae afti									
1			Due to	(or as a conseq	dence di):									
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nysician/Medical	IF FEMALE:													
an/	23b. Was decedent in the past 12		23c. If yes, ou	tcome of pregna birth 2 Feta	ancy il death 3 [☐ Ectopic pregnar	ncy				23d. Date Mont		Year	
밍	1 ☐ Yes 2 ☐	No	4 ☐ Preg	nant at time of one	death 5	Other (specify)					MOIII	h Day	Tear	
Z S	9 Unknown													
	Part II. Other signif	ricant conditi	ions contributing to d	leath but not res	ulting in the u	nderlying cause g	iven in Part	I.					use of death?	
ed by									1 🗆	Yes :	2 □ No 3	☐ Probably	4 🗹 Unkno	WΠ
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ا ه	25. Was case refer	red to medica	i I				OC Dies	e of Death	1 Tyes	1.4	10 1 L	Yes 25	No	_
Ď	examiner? 1 ☐ Yes 2 ᡚ		Hospital:	Inpatient 2	EB/Outpaties	2000	thor.		(Check only			(T = 11)		
- 1	27. Manner of Deatl		28a. Date		28b. Time of	IL 3 LI DOA	4 L N		ne 5 Res 28d. Describe					_
01	1 Natural	5 ☐ Pendir investi	ng (Mor	nth, Day, Year)	Injury	f 28c. Inj W	ork? ⊒Yes 2⊟		.ou. Doconbo	non inj	ary occurred			
Ca	2 ☐ Accident 3 ☐ Suicide	6 Could	not be	of Injury - At he	me farm etr	eet, factory, office			28f. Location	/C4===4	and Alcomban	or Dural Da	uto Mumbar	
Certification:	4 ☐ Homicide	detern	nined build	ing, etc. (Specif	fy)	eet, ractory, office		'	City or To			or nurai no	ute Number,	
	29a. Certifier	1 V Cartifui	na Physician: To the	n hact of my kno	wlodgo doot	h occurred at the	time date o	nd place a	and due to the		/a\ a==d ma==a			-
edical	(Check only one)	2 Medical	ng Physician: To the I Examiner: On the t and mar	pasis of examina ner stated.	ation and/or in	ivestigation, in my	opinion, de	ath occurre	and due to the ed at the time	, date a	(s) and man nd place, an	ner as state d due to the	cause(s)	
Ž	29b. Signature and	title of certifie	er			29c. Licer	ise number			29d. D	ate signed (Month, Day,	Year)	
	1	3-	- 0	0		40	0682	14		Del	e.m.t	ner 1	,200	9
	30. Name and addr	ess of person	who completed cau	se of death (Iten	n 23a) (Type,	Print\								
	Y	12000	270	D 0	. 1	I/a Da	1 6	140	290	0	11:	- 1/1	217	~A

Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Raymond Robert Fadeley, Sr. 2009 5:27A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Air Harford 5. Social Security Number 6. Sex. 1 HM 2 🗆 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 2/20/1931 Days Min Mary land 214 26 6535 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Harford Maryland 1 🗌 Yes 2 X No Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 908 Calvary road 21028 U.S.A. "natural", or items Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black White etc. 1 Never Married Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 🏝 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Technician Automotive 10 Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Albert Fadeley Esther Ann Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Mae Fadeley / wife 908 Calvary Rd, Churchville, MD 21028 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, Pennsylvania permit. Page 1 a
Department of F
Important: If ite
any injury or oth cemetery, crematory or other place) Ferris & Co. 12/2/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral To Tarring-Cargo Funeral Home, P 333 S. Parke St. Aberdeen, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line MYCOR DAL INFACTION Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes မ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my policing death. 29a. Certifier (Check Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Harr

31. Date filed (Month, Day, Year)

DEC 0 2 2009

and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Mary Jane Gutermuth 28, 2009 5:20 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/01/1952 If Unde Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 ☐ M 2 🖾 F Hours 217-52-8563 58 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Macical Examilier mast be rediffed at MD Baltimore Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7724 North Cove Road 21219 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Holloway Mary Wilma Betterton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Christine Scott / Daughter 7 Loring Court, Apt. C, Baltimore, MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/2/2009 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorota Marshall 22. Name and Address of Facility Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Amoria days brain disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Renal wech Sequentially list conditions, Examiner Daie to (or as a sonsequence of) cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed Mepho lithiasis that initiated events resulting in death) Last Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical Urosepsis mont IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ PEA arrest 1 Yes 2 No 3 Probably 4 Unknown Completed H77 Were autopsy findings available prior to completion of cause of death? autopsy performe Diabetes 2 No 1 □ Yes 2 1 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à determined 4 Homicide within 24 hours a 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47223 11-29-09 Durmotono MD

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Charles St Swte 5218

Baltimore mozIZ44

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen M. Lynn Piper

Ypark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4.00 PM 1115 2009 Laverne Green 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUSPITAL BALTIMORE AGNES 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 🖼 201-22-4676 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Expediment must be redified at 1 Yes 2 No Director timore 10e. Street and Number 10g. Citizen of What Country? USA 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☑No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retjred) College (1-4or 5+) Elementary/Secondary (0-12) eache alth and Mental Hv 17. Father's Name (First, Middle, Last) Be Lewis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Nymber, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Columbia MD 21045 ane 20b. Place of Disposition (Name of Disposition (Name of Disposition) (Name of Dispositio 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State altimore 4 ☐ Donation 5 ☐ Other (Specify) Errene Funtral Salva 22. Name and Address of Facility Vausha C 21. Signature of Funeral Service License PiKe 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA **Physician** 11/23/ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION UN COSWN Sequentially list conditions, if any least good and cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed MULTIPLE CEREBRAL UNKROWN burial-tran Due to (or as a consequence of): physician the burial UNKNOWN MELLITUS DIABETED Physician/Medical attending p as Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery law requires that the death 3 Ectopic pregnancy Month Day Year 5 Cher (specify) ed by the a detached f P.O. 1 ☐Yes 2 ☐ No 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 24 255 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? The certificate 1 ☐Yes 2 No 1 ☐Yes 2.☑No Division of Vital or Attending Physiclan: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 Pending investigation death 1 ☐ Yes 2 ☐ No within 24 hours after death
To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2 Medical Examiner: On the basis of rexamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 24 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING 000,78948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar PLACE

Surt

34

BALTIMONE MD 2/201

09-09098 Sherri Gross Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

em Gioss		For State	Certificate		Reg.	201	09 3831				
Physician	n/	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death				
edical Examin		Sherri A.	,	Gross 4b. City, Town, or Location	Month November 2	2, 2009 4c. County of Death	2024 hrs				
		Facility Name (if not institution, give street and number) Good Samaritan Hospital		Baltimore	or Death	40. County of Dodain					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		er 24Hrs. 8. Date of Birth((MM/DD/YYYY) 9. Birtl Foreign	nplace (State or				
Director	2	220-80-1146 1 M X F	46	Yrs. Months Days Hours	^s Min. 05 17	63 63	intry) MD				
ž.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
now an		MD NA	•	timore			1 X Yes 2 No				
arylan 8a-f st at ong	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	try?				
ı with the Maryland ms 23a or 28a-f show any be notified at once.	ä	1645 Wadsworth Way		21239		U.S.	Α.				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,				
ter dea		3 Widowed 4 Divorced If Yes, Give Yeer	No 1	Yes 2X No specify	.	Specify: Bl	ack				
ours afi atural	핡	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Dece	dent's Usual Occupation (Give most of working life. DO NO	kind of work done	16b. Kind of Business/I	ndustry				
n 72 hc	Completed by	Elementary/Secondary (0-12) Coilege (1-4 or 5+	-)		use remed)	Haircut	tory				
-003 I withii giene. ther the	E I	12th grade 2yrs 17. Father's Name (First, Middle, Last)	Cos	smetologist 18.Mothe	er's Name (First, Middle, Ma		rery				
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c ewent, the Medical Examine.	Bec	William H. Gross		Joa	nne Kelly						
21 hould nd Mer is man		19a. Informant's Name/Relationship (Type, Print)		iling Address (Street and Nu 15 Wadsworth							
and 2 shou fealth and N tem 27 is n traumatic	-	Dedrick Morgan-Son 20a. Method of Disposition		position (Name of cemetery,		20c. Location - City or					
nore ages 1 a nt of H nt: If it		1 X Burial 2 Cremation 3 Removal from State	e crematory o	rotherplace) emorial Park	12/21/09	Woodlaw	n, Md				
Balting permit. Per Departmet Importantinjury or	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	R	A Name and Address of Facil	itst.						
Dep Dep Militia		Jala March	4	1300 Wabash	Ave, Balti						
Physician / Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
kaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
		Sequentially list conditions, b									
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Ciscassos injury this lighted of C.									
sit d	Examiner	events resulting in death) Last Due to (or as a consequence of):									
executed an and al - transit		d. UNPENDED X AMENDED	"001 =		0 110	····					
Box 68760, e death certificate be extremed the attending physician red for use as the burial		IF FEMALE: 23c. If yes, outcom		TH,G898,12/8/0	9,WS	23d. Date of deliver	у				
687 certific rding p	ian/	23b. Was decedent pregnant in the past 12 months?	ime of death		pic pregnancy	Month	Day Y ear				
Box 687 death certific the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown	ime or death 5	Other (Specify)							
P.O. B	by Pr		but not resulting in	the underlying cause given in		bacco use contribute to					
S, P quires t an sign		Diabetes			24a. Was a		utopsy findings available				
cords, law require has been 2 should	ompleted	Obesity			autops perfor	sy prior to	completion of cause of				
Vital Rec ysician: The his certificate director, page	ပ	25. Was case referred to medical		26 Place of Dea	th (Check only one)	2 No 1 Y	es 2 No				
/ital	o Be	eyaminer?	nt 2 🗸 ER/Outpa	Other		Residence 6 Othe	er:				
n of \ ding Phy.	\vdash	27. Manner of Death 28a. Date of Inju	ry 28b. Time			now injury occurred					
sion ttendi death. ctor:	atio	Pending Accident Investigation		1 Yes 2		Street and Number or E	tural Route Number, City				
Division of Vital Records, tat or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should I	Certification:	Suicide Could not be determined (Specific)	ury - At nome, farm,	street, factory, office building,	or Town, S		drai Route Number, Oity				
Hospit 24 hour Funers		29a. Certifier 1 Certifying Physician: To the best of my	/ knowledge, death o	occurred at the time, date and	place, and due to the caus	e(s) and manner as sta	ated.				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil.	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or inves	stigation, in my opinion, death	occurred at the time, date a	and place, and due to	the cause(s)				
	Ž	29b. Signature and rivide of certifier	208t	29c. License numb	er	29d. Date signed (M November 23, 2					
		30. Name and address of person who completed cause of d	eath (Item 23a)	J.J.IVI.E.		1.0.3.11.001.20, 2					
		Victor Weedn MD JD Assistant Medical		11 Penn Street, Baltim	ore, MD 21201						
St Regist	ate		r's Signature	as)							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State	e of Maryland				lental Hygie	ne	
	_		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	reatri	Reg. 2. Date of Death	No. 200	9
	Physician/ JAMES S. GULDAN							Month NOV. 2	2009 2009 Year	5:45PM M
	Examin		4a. Facility Name (if not institution, give street and		4b. City, Town, or	Location of Death	11011	4c. County of Dea		
			11035 Pulaski Highway		White M			Baltimo		
	Funeral Director		5. Social Security Number 6. Sex 1 🔀 M 2	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes 07/30/192	g. Bir Co	thplace (State or Foreign untry)
			214-20-4917 Sual Residence of Decedent	85	110.			10//30/192	24 Ma	ryland
	f show	tor	10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	Man, 28a- notifie	irec	MD Baltimore	Whi	te Ma					1 🗆 Yes 2X No
	th the	la	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	ath w	Funeral Director	11035 Pulaski Highwa 11. Mantal Status 12. Was	Decedent Ever in U.S.	13. V	21162 Vas Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	U.S.A.	erican Indian
9	or ite	by F	1 ☐ Never Married 2 🔀 Married 1 🔀	ed Forces? Yes 2 No	11	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
8	ursaf ural", al Exa	ted	3 U Widowed 4 U Divorced Year	s, Give or Dates. WW II	_ 1	☐ Yes 2 X No	Specify:		Specify: Whi	ite
15-	72 hours after death with the Maryland n"matural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp	eted)	(Give F	lent's Usual Occupa kind of work done d O NOT use retired)	ation Juring most of worki	ing 16t	o. Kind of Business	Industry
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שַר	be filed v ental Hyg 'ked othe ic event,		17. Father's Name (First, Middle, Last)			OWINE	18. Mother's Name	e (First, Middle, Maid		100
ylaı	should be file n and Mental I r is marked o raumatic eve	욘	Joseph Guldan				Amelia I	Hodelick		
Mar	shou hand 7 is m rraum		19a. Informant's Name/Relationship (Type, Print)					al Route Number, City		· · · · · · · · · · · · · · · · · · ·
e,	and 2 s Health tem 27		Patricia Guldan (wi			5 Pulaski sition (Name of			Marsh, Ma c. Location - City or	ryland 21162
nor	Page 1 ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State cer	netery, cren	natory or other plac	e)	4/2009 E1	•	
Baltimore, Maryland 21215-0036	교문단을		21. Signature of Funeral Service Licensee	меаи						1 Home, P.A.
ä	Depar Impor any in		C. S. Kassak	ns						Land 21087
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. on each line.	Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between
्रव	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	Jon Sm	all	Cell	Lung	Cancel		23 months
أرسينا	Examiner		Du Du	e to (or as a conseque	nce of):		Ű	3		:
	- 42	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	n to (ur as e conseque	rine of):					
V	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.							
28	exectian article	E	resulting in death) Last Du	e to (or as a conseque	nce of):					
90	icate be executed I physician and s the burial-transit	edical	d							
Box 68760	ertifica ding p		IF FEMALE: 23b. Was decedent pregnant 23c. If ye	s, outcome of pregnanc	ov.				00d Date of de	discours :
XO	requires that the death certific been signed by the attending p should be detached for use as	Physician/M	in the past 12 months?	Live Birth 2 Petal of Pregnant at time of dea	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	Day Year
	the de by the achec	hys	g Unknown	Unknown						
P .	s that gned l	by F	Part II. Other significant conditions contributing	to death but not result	ting in the u	nderlying cause giv	en in Part I.			the cause of death?
ds,	equire een si	ted						1 Yes	2 □ No 3 □ P	robably 4 Unknown
000	law ru has b ie 2 sh	Completed						24a. Was an autopsy performed	prior to	topsy findings available completion of cause of
m m	n: The ficate rr, pag		25. Was case referred to medical			00.00	4 Po 111 494 F 1	1 🗆 Yes 2 🔀		s 2 No
/ita	siciar s certir lirecto	To Be	examiner?	1 ☐ Inpatient 2 ☐ El	P/Outpation	Othe	ace of Death (Check	me 5 K Residence	. C □ Other (Cree	
of/	g Phy er this heral c		27. Manner of Death 28a.		8b. Time of injury	28c. Injury	at	28d. Describe how in		sily)
on	endin eath. or: Aft he fur	fica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(World), Bay, Year)	injury	M 1 🗆	Yes 2 No			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Certificate:	4 Homicide determined 286.	Place of Injury - At hom ouilding, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Street City or Town, St		ral Route Number,
Ω	spital		29a. Certifier 1 Certifying Physician: To	the best of my knowled	dae, death c	occured at the time.	date and place, an	d due to the cause(s	and manner as st	ated.
	n 24 h	Medical	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practic	e basis of examination a	ınd/or invest	igation, in my opinio	n, death occurred at	the time, date and pl	ace, and due to the	cause(s) and manner stated.
	To the Vithin Com		29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Mont	h, Day, Year)
	, ,		yanel Croper	mp		104	6118	N	OU 23	2009
	6+1		30. Name and address of person who completed	cause of death (Item 2	3a) (Type, P	rint)	ovk R	d /.	Vhomill+	MD 21193
	Stat	e	31. Date filed (Month, Day, Year)	32. Pigistrar's Signatur	e		-11	or ru	1- would	- TOOLS
	Registra	_	MFC 0 2 2009	Janes 1	1 1	arkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1,30 A Physician Month ZE ATRICIA /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and number) Examiner USP17742 TIMORE 8. Date of Birth (Month, Day, Year) 6-18-1951 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2√2 F 216-50-2413 58 MD Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits works event, the Medical Examiner must be notified at 1 XYes 2 □ No Director MD n/a Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 6040 Barston Road Apt A 21206 S A Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 72 hours after or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates: \$ 3 ☐ Widowed 4 🛣 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Its Ma Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Adminstrated Officer 12th grade years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hodges McCray Josephine Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5622 Sinclair Lane Marvin McCray - Son Apt G. Balto, MD 21206 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕏 Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial 12-7-2009 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licenses 1101 E. North Avenue 10 Balto, MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASSIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MONIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760 physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. the 9 Unknown signed by to be a detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After thi 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Registrar



30. Name and address of Ferson who completed cause of death (Item 23a) (Type, Print)

Year)

PAUL PLACE

BAZATROPE MO ZIZII

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OVER BER Year EV/1/219 7:12F M Marie Josephine Hoffer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Saint Joseph Medical Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Jan. 1929 Days Hours Min. Massachusetts 80 **Director** 013-22-8377 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 🌠 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 324 Stevenson Lane 21204 Apt. A-3U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian was becedent Ever In U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates 1954–58 Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse years Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Johanna Lynch Tiernan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Maits (daughter) Glen Alpine Road Phoenix, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 12-7-09 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Maryl 21. Signature of Funeral Service Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ AORTA RUPTURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ADRTIC DISSECTION Sequentially list conditions, it cays trading to immediate cause. Enter Underlying Examine Due to for as a consequence of sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes ၀ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Hospital or Attending Physician; The law requires that the death certificate be

State Registrar only one)

30. Name and

29b. Signature and title of certifier

CUNNINGHAM 31. Date filed (Month, Day, Year) egistrar's Signature DEC 02

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D

OSLER DRIVE.

39215

TOWSON.

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylar						lental Hy	giene	Э			
		rtifica	te of E		Reg. No. 2000 39321											
	Dhyaiai		1. Oecedent's Name (First, Middle, Last)										2. Date of Death Month Day			Death
	Physici /Medic	/Medical Elizabeth B. Hopkins										1 00 000			A M	
	Examin	Examiner 4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death					4c. County of Death				
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	Funeral		5. Social Security Number	6. Sex 1 □ M 2 □ F	7. Age (In yrs.		Months		If Under Hours	Min.	8. Date of Bi (Month, D	ay, Year)		Coun		-
	Director		579-20-3565 Usual Residence of Decedent	X	9	3 Yrs.					Sept.	22 1	916	Wash:	ington	, DC
	land ow tt		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside C	ity Limits
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21215-0036	within	m	Elementary/Secondary (0-12)		e. DO NOT use retired) Susiness Owner											
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ä	d be i	Be C	John F. Butler	Luciy					_				Juman	16)		
Maryland	2 should be filed within 72 hours after death with the Marylan is and Mental Hyglene and Mental Hyglene han "hatural", or items 23a or 28a-f show marked other than "hatural", or items 23a or 28a-f show are marked other the Medical Examiner must be notified at raumatic event, the Medical Examiner must be notified at	မ	19a. Informant's Name/Relations	hip (Type Print)		19h Mailir	na Addres	s (Street e			. Youn	ng mber, City or Town, State, Zip Code)				
<u>8</u>	d 2 s Ith ar 27 is trau		Earl W. McKnig		on		-						·		Code)	
စ်	es 1 and 2 should of Health and Mer tem 27 is marke cother traumatic		20a. Method of Disposition	ire/ drands	20b. F	Place of Dispo	sition (Na	me of			or Mil			1244 City or To	wn, State	
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de sign	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one duse on each line. Immediate cause (Final disease or condition Dementia										Death			
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	the d y the	ysi	9☐Unknown	9□Unkr												
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UNISION	or At fter d Sirect in by	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									mber,				
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	5.,		30. Name and address of person	who completed cau	se of death (Iten	1 23a) (Type	Print)	D452	. ⊥ /			NC	vemb	per 2	4, 20	U 9
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Inf G898 12/29/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Year **Physician** Ellen Helfman Jovember 10:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE PIKESVILLE 3214 TIMBERFIELD LANE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 06/21/1950 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F 59 MD 213-58-0355 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene.

Nher than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It's Medical Examiner must be notified at 1 ☐ Yes 2 💢 No Director MD BALTIMORE PIKESVILLE 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 3214 TIMBERFIELD LANE USA 21208 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 X No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRITZ KREISLER RUTH FLEHINGER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21208 JAMES HELFMAN / HUSBAND 3214 TIMBERFIELD LANE, PIKESVILLE, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED | 12/01/2009 RANDALLSTOWN, MD 1 Donation 5 Other (Specify) neral Services 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. P. If 1. Enter the disease, ar complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year Physician Brain 19295 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1ear Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐Yes 2 ☑No Pregnant at time of death 5 Other (specify) 9 M Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 □Yes 2 □ No investigation hours after death. uneral Director: A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 30,2009

State Registrar

DHMH 17 Rev 1/2001

Road Suit

Polosville, mD 21205

30. Name and address Hourson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State of M	aryland / [Depa <i>Cen</i>	irtment of H <i>tificate of D</i>	ealth and l eath	Mental Hy	giene (Reg. No.	2009	38323
		1. Decedent's Name (First, Middle, Last)							2. Date of De	ath	Voor	3. Time of Death
	Physicia Medic	edical Gerald Hill Isaa							Novemb		, 2009	3:16 PM
	Examin	4a. Facility Name (if not institution, give street and number) Dove House					4b. City, Town, or Location of Death Westminster Carrol					
	Funeral		5. Social Security Number	hday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	h	9. Birth	nplace (State or Foreign		
	Director		215-28-1626 Usual Residence of Decedent	1 X M 2 □ F	79	Yrs.			(Month, Da Sept 8	, 193	930 Maryland	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State 10b. County		10c. City, Town	n or Loc	ation			10d. Inside City Limits		
	e Mary r 28a-1 notifie	Director	MD Howard	<u> </u>	Savage		10f. Zip Code			40 - Oilin	en of What Cou	1 🛛 Yes 2 🗆 No
	vith th		8890 Lincoln St	reet			20763			U.S		anu y s
	items		11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V	las Decedent of His Yes, specify Cubar	spanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No-		4. Race - Ameri Black, White	
36	after or samir	d by	1 ☐ Never Married 2 🔀 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 X Yes 2 I	No 1953-56	1	☐ Yes 2 🔀 No		,	S	pecify: Whit	
9	hours natura dical E	Completed	15. Deceden	t's Education		. Deced	ent's Usual Occupa	ition	kina		d of Business I	
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/lan	d be fil Vental arked atic ev	잍	Columbus Isaacs					Beatric	e Hill			
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e, N	and 2 Health tem 2;		Gerald H. Isaac	cs, Jr. / so			Woodward sition (Name of	Street,	Date		ation - City or	
E I	Page 1 nent of int; If i		1 ☐ Burial 2 🏻 Cremation 4 ☐ Donation 5 ☐ Other (S	3 🗋 Removal from State	cemete	ry, crem	natory or other place 1 Cremato			Oden	ton, Ma	aryland
Baltimore, Maryland 21215-0036	permit. Departn Importa any inju		21. Signature of Funeral Service L	ce see	1400==0	22 Do	Name and Addres	s of Facility Funeral	Home, P	.A.		
	<u></u>	K_S	23a Part 1 Enter the disease or	complications that cause	M00773		the mode of dvino				and 207	707-4389 Approximate
ú	Physician/	9 73	shock, or heartyfailure. List only one cause on each line. Interval Between Onset and Death									
	Medical Examiner		disease or condition resulting in death)		a consequence		Myelomas					
	Examiner	ē	End Stage Renal Disease Due to (or as a consequence of):									
	ted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Congestive Heart Failure									
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200	cate be executed physician and s the burial-transit	edical		d								
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0	at the ed by th	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death part II.									the cause of death?
S, F	uires th n signe ild be o	d be							1 🗆	Yes 2	No 3□Pr	obably 4 🛭 Unknown
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Bec	The la	Con							1 🗆 Yes	ormed? 2X No	death?	2 🗆 No
ita	sician: certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			Othe	ace of Death (Che			700 00	
of <	g Physer this eral di	e: To	27. Manner of Death	28a. Date of inju		Time of	28c. Injury	at	lome 5 Resi			(fy)
O	eath. or: Aft	ficat	1 X Natural 5 ☐ Pendin 2 ☐ Accident Investiç 3 ☐ Sulcide 6 ☐ Could	ation		injury		Yes 2 No				
NSI	or Att after d Directe in by 1	Certificate:	4 Homicide determ	ined 28e. Place of Inj	ury - At home, fa c. (Spec <i>ify)</i>	arm, stre	eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying	Physician: To the best o	f my knowledge,	death o	occured at the time,	date and place, a	and due to the ca	use(s) and	manner as sta	ted. cause(s) and manner stated.
	To the He within 24 To the Fu	Mec	only one) 3 Certifying	Nurse Practioner: To the			death occurred at the	e time, date and pla		ne cause(s)	and manner as	stated.
	5		29b. Signature and title of certifier	E () mer			29c. License D3064				signed <i>(Month</i> ember 20	
	8+1		30. Name and address of person									
	0, 1		Ramesh Sabapa				ck River	Neck Roa	d, Balt	imore	, Mary	land 21221
	Sta Registr		31. Date filed (Month, Day Year)) 2 2009 ^{2. Regi}	ar's Signature	A. 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PII and 25 per MF 2898 12/17/09 TT
State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Nover 9:05AM 26 200 10)ar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ACTIMORE Ber 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, AGNES HOSPITAL 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 213-30-2128 1 ☐ M 2 🗗 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Exercitivat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Director timore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2122 Funeral 12. Was Decedent Ever in LAS Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify <u>چ</u> 3 ₩idowed 4 ☐ Divorced Black
Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (2) 2) College (1-4or 5+) lerica Ld 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 68 Balto. MD21229 101u 20b. Place of Disposition (Name of metery, crematory or other place) 20a. Method of Disposition 3 Removal from State 1 Surial 2 ☐ Cremation 4 □ Donation 5 □ Other (Specify) 21. Situative of Funeral Service Licensee . Greene Funeral Services Balto. MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic rectal carcinama /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consenuable off death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760, CERTIFICA Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 ☐ Other (specify) Ö been signed by the should be detached 9 Ulnknown 9 ☐ Unknown <u>~</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Delvic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed and 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2: autopsy performed certificate 25. Was case referred to medical examiner? monas abdominal 2 No 2 No Yes 1 Yes Be director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To completely filled in by the funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deat e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. within 2 To the 29b. Signature and title of Artifier 29c. License number 29d. Date signed (Month, Day, Year) 4181 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 ATO AVE 32. Registra s Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend, 19a, per Fh g898 12/2/09 TT
State of Maryland 7 Department of Health and Mental Hygiene 2000 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 115 lones 8:45PM 1-30-2009 /Medical 4a. Facility Name (If not institution, give street and ity. Town, or Location of Death County of Death Examiner anor Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🗹 F Months Days Min. 7-38-605 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In a Medical Examinar must be retified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No <u>გ</u> Specify: 3 Widowed 4 □ Divorced Dlac Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-y2) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 50 2 19b. Mailing Address (Street and Number Rural Route Number, City or Town, State, Zip Code) 10 dibei Baltimore, 0b. Place of Disposition (Name of opmetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility C. Greene Funeral Services auchn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC Immediate Cause (Final **Physician** RENAL CELL CARCINDMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1 🗆 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4ENursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 2 Accident 1 ☐Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059107 M.D 2-01-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

mA

31. Date filed (Month, Day, Year)

210

BUSINESS

32. Registrar's Signature

Barka

CENTER

REISTER

DRIVE

MD 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38326 Reg. No. 2 0 Certificate of Death Decedent's Name, (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician MWood ones 4:20 AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner nenesis Meny land Saltimore Raver Baltimore och 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 212629798 Months Days Hours Min 56 Director 4-15-1953 MD Usual Residence of Decedent la or 28a-f show t be notified at 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 1 Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? is 1 and 2 should be filed within 72 hours after death wi of Health and Mental Hygiens. Thattural", or items 23a Item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b. 2 should be filed within 72 hours after death nand Mental Hygiene. Is marked other than "natural" or items 23s Funeral 2343 Montebello Terrace USA 21214 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black à 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)n/a Elementary/Secondary (0-12) Disabled Disabled 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen Fulwood Edith Burroughs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hassan Jones-Son 2343 Montebello Terrace Balto, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 11-28-09 Randallstown, MD 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine 1 month hellmorria the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. I signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ INOU 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy performe certificate 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) Type, Print) 32 Registrar's Signature

Bark

720

R113807

Emge Rd, Baltimore 21234

Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 signed by the a P.O. Records, peen page 2 s this certificate Division of Vital 24 hours after death.

Funeral Director: After

Examine Physician/Medical 2 Completed funeral director, æ ပ Certificate: completed filled in by the Medical

Physician/

Medical

Examiner

Funeral

Director

28a-f shov

Director

Funeral

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Completed

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ral", or items 23a or 28a-f sho Examiner must be notified at

"natural"

the Medical

27 is marked other than r traumatic event, the Me

Department of Healtl Important: If item 2 any injury or other tonce. injury or other

Physician/

Medical

Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene.

and Mental Hygiene

death

Baltimore, Maryland 21215-0036

the within To the State 27. Manner of Death

29a. Certifier

6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my entities.

D0061662

Square Drive Ba

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 11/30/2009

ss of person who completed cause of death (Item 23a) (Type, Print

Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Roland Caro1 Jewett, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Kosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Ye 1 **XX**M 2 □ F Months Hours Min. Year) Maryland 220-18-3477 Director Feb. Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 X No Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1812 Hanford Road 21237 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces? Black, White, etc. ۾ 1 Never Married 2XXMarried Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify: Completed 3 Widowed 4 Divorced White at of Health and Mental Hygiene.
If item 27 is marked other than "nature or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Coast Guard 7th. Grade Pipe Fitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Roland Carol Jewett, Sr. Katherine Rave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1812 Hanford Road Baltimore MD 21237 Jean Jewett/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Department of Importants If any injury or Faith Cem. 11/30/2009 4 ☐ Donation 5 ☐ Other (Specify) of Baltimore MD Gardens 21. Sig profe of Funera) Service License 22. Name and Address of Facility Miller-Dippel Funeral Home, 6415 Belair Road Baltimore Part 1. Enter the disease, or omy shock, or heart failure. List only Onset and Death Immediate Cause (Final Atheroscleroti Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy Hospital or Attending Physician: The Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2**X** No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 541 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059793 Nov 25, 7009 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 21237 Pavid E Fernie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ewet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# / & 19b, per FH, G898, 1278/09, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 3:55AM NOVEMBER 27 2009 Kennedy Mae /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Baltimore Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 💢 F 71 77 Director 249-46-6064 29 SC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, It e Medical Examiner must be notified at once. YYes 2 □ No Baltimore Directo NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 U.S.A. 4001 Clarks Lane Apt 410 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify ò Specify: 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laundry Worker Uniform Company 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Conyers Selvin Bowman ည 19a. Informant's Name/Relationship (Type. Print) Daugher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17403 7259 North Sentinel Lane, York, PA 17430 Vanessa Kennedy Hamilton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 D Burial 2 □ Cremation 3 □ Removal from State 11/30/09 Woodlawn, Md King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Marchod Flyff of Wellst 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death It. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocarclia 2 days **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque ce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): and resulting in death) Last Due to (or as a consequence of) nding physician a use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? signed by the atter 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No 1 ☐ Yes 210No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Y RES-000 November, 27 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

the Maryland

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be

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Division of Vital Records,

Sinai

Gadekar

Year)

Date filed (Month, Day,

Hospital of Baltimore

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deatl 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** November 2013 24, 2009 Usha V. Kharod /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. (State or Foreign 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🛣 F Yrs. 74 Sept 1, Director 214-06-5260 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Econolinar must be notified at 1 □Yes 2 XNo Director Montgomery Village Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20886 9804 Dellcastle Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 X No Specify: Specify: Asian-Indian <u>چ</u> 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education 12 should be filed with and Mental Hygier 7 is marked other th 5+ Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vaishnav Daulatben Shankarlal Mankad ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
D partment of Health ar
Important: If item 27 is
amy Injury or other trau 20325 Sandsfield Terrace Germantown, Maryland 20876 Chetan Kharod/son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Arundel Crematory 11/27/2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home & Crematory, 21. Signature of Funeral Service License XIIIomas 1411 Annapolis Road Odenton, Maryland 21113 uanita Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 💢 No ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2× No 1 □ Yes 3 Probably 4 Unknown cate has been s page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2/2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056345 30. Name and address of perion who completed cause of death (Item 23a) (Type, Print) 19745 Executive Park Circle Germantown, Maryland 20874 Piyush K. Patel, M.D. 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 2898 12-2-09 State of Maryland Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 28^D2009 3:58 P Margaret Eleonora Lassahn Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3825 Bay Drive Baltimore Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🙀 F Months Days Hours (Month, Day, Year February 23 93 212 40 6917 Director 1916 Baltimore Co., MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertall Hyglene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Baltimore Baltimore County Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3825 Bay Drive 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes XX No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates Specify: White ¾X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Housewife Housekeeping-Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles August Albrecht Margaret Elizabeth Barbour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 840 Luthardt Road Baltimore, Maryland 21220 Edgar F. Lassahn Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State St. Paul Luth. Ch. Cem. 12-2-09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road Kingsville, Maryland 21087 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart Physician/ maestire disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner cutinaia Section is any list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Osteoarthintis . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 6 Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) ス D37133

State Registrar

DHMH 17 Rev 7/2009

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32. Pegiskar's Signature

Osler Dure #219

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DULL MD

31. Date filed (Month, Day, Year)

			For State of Maryland / De	partment of Health an	nd Mental Hygier	ne 2009 38332
		-	Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg.	No. 2 3. Time of Death
	Physicia Medio		Ruth	McLean		Day Year
1	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	Death	4c. County of Death
-1	·		2612 Quantico Ave 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Baltimore		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 7. Age (In yrs. last bir	Months Dave Hours A	Hrs. 8. Date of Birth Min. Month, Day, Yea 10 25	9. Birthplace (State or Foreign Country) NC
			Usual Residence of Decedent		110 20	
	uyland a-f sh ied al	Director	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1X Yes 2 □ No
	or 28		MD NA Ball	timore 10f. Zip Code	10a.	Citizen of What Country?
	with t	Funeral	2612 Quantico Ave	21215		U.S.A.
	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Fun	Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Per	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
35	al", or	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No If Yes, Give 1 Year or Dates.	1 ☐ Yes 2 No Specify:		Specify: Black
ָה ה	hours, hours	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation	Two ding	. Kind of Business Industry
12	thin 72 sne. than '	mo.	Elementary/Seconday (0-12) College (1-4 or 5+)	. DO NOT use retired)		ursing Home
Ö	ed wil Hygie other ent, tt	Be C	8th grade na Nur 17. Father's Name (First, Middle, Last)	ses Assistance	Name (First, Middle, Maide	
lan I	d be fill fental irked tic ev	မ	Samuel Isaac	•	McDuffy	on curriantly
Maryland 21215-0036	shoulk and N is ma			ailing Address (Street and Number of		
o, S	and 2 Health em 27 ther tr		Dicited Hilliams Languists	Brookeberry		MD SII30
nor	age 1 ent of it: If it		1 ▼ Burial 2 □ Cremation 3 □ Removal from State cemetery, of	sposition (Name of crematory or other place)	ľ	Location - City or Town, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee			rbutus, Md
ñ	permir Depar Impor any in		Monette K. Jones	22. Name and Address of Facility March F/H Wes 4300 Wabash A	t <u>ve, Baltim</u>	ore, Md 21215
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as care	rdiac or respiratory arrest,	Approximate Interval Between
1	nysician/ Medical		resulting in death)	Cer		Onset and Death, 3 months
_	Examiner		Due to (or as Consequence of):			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):			
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200	th cert ttendir or use	ian/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death			23d. Date of delivery
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ďs,	quires en sig ould b	ted	Congestive heart faile	Ire.	1 ✓ Yes	2 No 3 Probably 4 Unknown
S	law re nas be e 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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Ita	rsiciar s certil	To Be	examiner? 1 Yes 2 No	26. Place of Death (Check only one) ing Home 5 🗷 Residence	a □ 011 × 70 × 71
10	ng Phy ter this neral o		27. Manner of Death 1 St Natural 5 Pending (Month, Day, Year) injur	of 28c. Injury at	28d. Describe how in	
0	tendir leath. tor: Af the fu	Certificate:	2 Accident Investigation	M 1 Yes 2 No	>	
Division of Vital Records,	l or At after o Direct	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occured at the time, date and place	ce, and due to the cause(s)	and manner as stated.
	the H hin 24 the Fu Tiplete	Mec	(Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practioner: To the best of my knowledge	e, death occurred at the time, date an	nd place, and due to the caus	se(s) and manner as stated.
	og avit		29b. Signature and title of certifier Yaulaga dola My	29c. License number D 59027	29d.	Date signed (Month, Day, Year)
Ļ			30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	1/2	A. 200
			30. Name and address of person who completed cause of death (Item 23a) (Typ Lavanya Yarlagadda MD 2401 W Be	Ivedere Avenue,	Baltimore 1	MD 21215
	Stat Registra	е	31. Date filed (Month, Day, Year) SFC 0 2 2009 37. Registrar's Signature	and I		
			DLU V N TOOL VOICE NO. 10.	Par Co.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 27 PM 2009 WEADOWS NILLIAM UU /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NA LOOD SAMARITAN JATIG20+) TIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 M M 2 □ F 65 212-44-7551 44 VA **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State show Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "natural", or items 23a or 28a-f shou any Injury or other traumatic event, the Medical Exprendictions and once.

Once. 1 XYes 2 No Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21207 U.S.A. 5404 Lewellen Ave Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 Hes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify. ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Mechanic 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ola Newman Charlie Meadows 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5404 Lewellen Ave, Baltimore, Md 21207 Duane Cozart-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 12/4/09 Owings Mills, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMUNAKY EMBOLISM **Physician** MAJJINE 0 m disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a equipaquence of: Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 5 ☐Pending investigation 14 Natural n 24 hours after death.

e Funeral Director: Af bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Registrar DHMH 17 Rev 1/2001

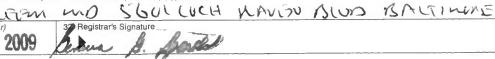
within 24 hor To the Fune completely fi

31. Date filed (Month, Day, Year) State

(Check only one)

29b. Signature and title of certifier

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and manner stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:27 PM November 28, 2009 William Edward Meyers, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) 11XM 2□ F Months Days 67 29, Maryland Director 216-36-2696 April 1942 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Anne Arundel Gambrills Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with United States 21054 917 Waugh Chapel Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iter 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: þ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Production Mechanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Dorothy Pauline Meyers, Sr. ပ William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gambrills, Maryland 21054 917 Waugh Chapel Road Brenda L. Meyers/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 12/1/2009 Odenton, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Donaldson Funeral Home & Crematory 1411 Annapolis Road Odenton, Maryland 21113 ianita Momao 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** > /week resulting in death) /Medical Due to (s a consequence of): Examiner ellu Sequentially list conditions, if any, leading to immediate cause. Enter Uncounty Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 papatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 28b. Time of Certification: 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier le. 1) 2800 11-29-2009

State Registrar whert

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 38335 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11/29/2009 3:04 A^M Robert Euell Mize, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8220 Crab Apple Court Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Year) Hours Days 1 X M 2 □ F 57 Director 212-60-9485 8/29/1952 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Molcal Examiner must be rediffed at Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8220 Crab Apple Court 21061 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 □Yes 2 🛣 No Š Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed with:
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than
any Injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) 11 Machinist Mechanical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Euell Mize Nellie Hodges 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Mize Wife 8220 Crab Apple Court, Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Loudon Park Cemetery 12/3/2009 Baltimore, Maryland of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 7 mios disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. 1 □Yes 2 □No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page his certificate h I director, page performed' 1 ☐Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo this 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) strar's Signature 31. Date filed (Month, State 2 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 38336 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2.56 PM dward. Edgar NOU do 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIA HOSPITAL BALTIMONE BALTIMORE OF If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Sex 1 M 2 □ F Yea Months Days Hours Min 24-52-6743 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2120 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Savice OOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howa Jesbitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. Battimore, MD ZIZO7 Wife 3017 Fendall 'atricia E. Nesbitt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burlal 2 □ Cremation 3 □ Removal from State on Forest 12-7-2009 Owings Mills, Mb 22. Name and Address of Facility Voughn C. Greene funeral sur harrison 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee RJ. Randalistom, mozu33 Qu 7281 iberty or complications that caused the death. Do not enter the mode of dying, such as carriac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disc as shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) ACUTE INFARCTION MIDCARDIOL Due to (or as a consequence of): HYPOGLY CEDIO NIGBETES -Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEPENDENT DIABFIES 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

burial-transi physician attending for use as certificate has been signed by the rector, page 2 should be detached ours after death.

eral Director: After this certific filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

7 Is marked other traumatic event, II

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permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr
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Physician

/Medical

Examiner

Funeral Director

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death with

Baltimore, Maryland 21215-0036

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Physician/Medical Be Completed by Medical Certification: To

24 hours a To the within 2 To the F <u>1</u> 0 State Registrar

29b. Signature and the of certifier

4 Homicide

29a. Certifier

RONKER MD

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

HOSPITAL

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11-25. 2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			_ FOI	artment of Health and Me	ntal Hygiene Reg. No 2009	9 38337
			Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death
	Physici		Carmen Rosario Pomares	No	Month Day Yes	
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of D	
	Examin	٠.	Fort Washington Hospital	Fort Washington	Prince (George's
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth 9. (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		143-50-1798 1□M 2X F 78 Yrs.			Cuba
	pu >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	ehov	5				1t☑Yes 2 No
	the N	Director	NJ Essex Bloomfie 10e. Street and Number	10f. Zip Code	10g. Citizen of What	
	with with	2				Cooming
	ne 23	Funeral	56 Monroe Place 11. Maritaf Status 12. Was Decedent Ever in U.S. 13	07003 Was Decedent of Hispanic Origin? (Specif	U.S.A. fv Yes or No- 14. Race - A	American Indian.
	ter d	F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.) Black, W	Vhite, etc.
9	ors e	by	3 ☐ Widowed 4 ☒ Divorced Year or Dates:	1 X Yes 2 □ No Specity: Cuba:	n Specify:	White
Ò	ited within 72 hours efter deeth with the Maryland Hygiene. other than "neturel", or iteme 23a or 28a-f ehow ent, the Medical Evaninar must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation s kind of work done during most of working	16b. Kind of Busine	ess/Industry
21	thin the	ag l	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
21	ed wi	S		urse		th Care
<u>n</u>	tal H d oth	Be	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Sumame)	
<u> </u>	Men Men Marka Marka	٦ ا	Jose A. Garcia		a A. Gonzalez	
<u>a</u>	12 sh h and 7 le m traum			ing Address (Street and Number or Rural F		(e, ZIP Code)
e,	1 and Healt em 2 ther		20a Method of Disposition 20b. Place of Disc	rayton Pl., Wayne, I	The state of the s	or Town, State
٥	nt of nt of t: # it		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place) of Memories 11/30/		shington, NJ
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show were injury or other traumatic event, the Medical Examination and be notified at ODGs.	. 4	4 Doublett 5 Doublet (opposity)	22. Name and Address of Facility	o, Imp of wa	oningcon, no
Ba	Dep den den den den den den den den den den		Langin Fellmon	J. Rivera Funeral Ho 4543 Kennedy Blvd.,	ome North Bergen, 1	NJ 07047
			23a. Part1. Enter the disease, or complications that caused the death. Do not en			Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Onset and Death
1	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):			
	Examiner		Sequentially list conditions b.			
	p ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
8	and Ind	Examiner	that inflated events C.			
8760,	sate be executed physicien and the burial-transit	<u> </u>	Due to (or as a consequence of):			
87	Attending Physician: The law requires that the death certificate be executed reash. reash. ector: Atter this certificate hes been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	dlcal	d.			
Box 6	leath certific attending pl	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of	delivery
Bo	thet the death cer ed by the attendin detached for use	clan	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)	Month	Day Year
P.O.	the d y the	lys	1 Yes 2 No 9 Unknown			
α, σ	res thet signed b	by PI	Part If. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part f.	23e. Did tobacco use contribut	te to the cause of death?
ğ	w require been sig should b				1 ☐ Yes 2 ☐ No 32	Probably 4 Unknown
ဝ္	aw requ ss been 2 shoul	Completed				e autopsy findings available to completion of cause of
Ĕ	The I	Eo			performed deat	
ita	ysician: The is certificete hu director, page	Bec	25. Was case referred to medical examiner?	26. Place of Death (
<u>_</u>	Physic this ce al dire	10	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
_	ther the		27. Manner of Death 1. ✓ Natural 5 ☐ Pending (Month, Day Year) Injury 1. ✓ Natural 5 ☐ Pending (Month, Day Year)	Work?	d. Describe how injury occurred	
Sio	tendi leath. tor: A	catl	2 Accident investigation	M 1 Yes 2 No		
Division of Vital Records,	or At	Certification:	4 Homicide determined 28e. Place of Injury - At home, larm, s	treet, lactory, office	II. Location (Street and Number of City or Town, State)	r Hurai Houle Number,
	Hospital		29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, an	d due to the cause(s) and manne	or as stated
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or	nvestigation, in my opinion, death occurred	at the time, date and place, and	due to the cause(s)
	To the within 2 To the Complet	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	fonth, Day, Year)
			Grantemen no ELAG	ady D0057632	2 11/	123/09
	4		30. Name and address of person who completed cause of death (Item 23a) (Type	p, Print)		
			James Mitchell MS 117/1	surystu Rd. Fr	or washing ,	40 20744
	Sta Registi	ite ar	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type Tames M. Inches M. 17711 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0.2. 2009			

		1	For State Of IVIS State Registrar	ryland / Depa Cer	tificate of D	eath	Reg. N	2009	38338
Ph	ysicia		1. Decedent's Name (First, Middle, Last) Herbert Lee Parker					Day Year	3. Time of Death
	Medic xamin	al .	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	1 hvanha	- <u> </u>	
J		•	Union Memorial Hosp	ital	Balti	more _		N/A	
Dire	neral ector		5. Social Security Number 212-42-8761 Column	(In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth A Mante, Pap Par	1945 New	place (State or Foreign ntry)
and	at at	ē	10a. State 10b. County	10c. City, Town or Loc	ation			T	10d. Inside City Limits
Maryl	otifier	irec	MD N/A		1 Ø Yes 2 □ No				
with the	nust be n	Funeral Director	1819 Swansea Rd.		10f. Zip Code 21239		Ŭ.	Citizen of What Cou	intry?
036 s after deat	important; if item 27 is marked other than "natural", or items 23a of 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Endmed Forces? 1 X Yes 2 Towns (Yes, Give Year or Dates A)	ver in U.S. 13. V No 1	Vas Decedent of His Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Black	, etc.
215-0	an "natul Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-	16a. Deced	lent's Usual Occupa kind of work done di O NOT use retired)	ation uring most of worki	ing 16b.	. Kind of Business Ir	
212 d withir lygiene	ner th	os h	12th N/A	Labo	orer			Industr	<u>Y</u>
be file	rked or	면 면	17. Father's Name (First, Middle, Last) Willie Parker			Sarah	e (First, Middle, Maide	Jones	
Mary	r traumal		19a. Informant's Name/Relationship (Type, Print) Sarah Parker/Mother	19b. Mailin 181	g Address (Street a	nd Number or Rura	al Route Number, City Balto., N	or Town, State, Zip MD 2123	
Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene.	ant: If item ury or othe		20a. Method of Disposition 1	20b. Place of Dispos cemetery, crem Garrisol	natory or other place	e)		Location - City or I	
Balti permit. Departr	any inju		21. Signature Fineral Service Licensee Falloward a Battle	22	Name and Addres Betts Fi	s of Facility ineral I	Home 1129	9 N. Cai	COLLAGE ST.
	edical miner	er	Sequentially list conditions.	consequence of):	er the mode of dying		or respiratory arrest,	3	Approximate Interval Between Onset and Death +5 Minutes
760 icate be executed	priyalcian and the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last c						
Division of Vital Records, P.O. Box 68: Hospital or Attending Physician: The law requires that the death certificate house after death.	signed by the attending plant of the detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome c 1 ☐ Live Birth : 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3 E	Ectopic pregnanc	у		23d. Date of deli Month	very Day Year
Is, P.O.	is signed by	by	Part II. Other significant conditions contributing to death but	ut not resulting in the u	nderlying cause giv	en in Part I.		o use contribute to	the cause of death?
Division of Vital Records, tal or Attending Physician: The law requires re after death.	page 2 should I	Completed					24a. Was an autopsy performed 1 Yes 2	prior to c	opsy findings available ompletion of cause of 2 X No
ician:	ector,	Be	25. Was case referred to medical examiner? Hospital:	and a	Othe	ace of Death (Checi			
of V	eral dir	e: To	27. Manner of Death 28a. Date of injur		nt 3 LJ DOA	4 ∐ Nursing Ho	ome 5 Residence 28d. Describe how in		fy)
on C ending sath.	he fund	ficat	1 Natural 5 Pending (Month, Day 2 Accident Investigation	Year) injury	M 1 🗆	? Yes 2 🗆 No	=		
Division Att	d in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (Street and City or Town, Sta		al Route Number,
e Hospita	e runera Neted fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of eyenly one) 3 Certifying Nurse Practioner: To the	amination and/or invest	tigation, in my opinio	n, death occurred a	t the time, date and pla	ace, and due to the c	ause(s) and manner stated.
Sec Sec									
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F	Print) Bruze	2 West	son ME)	- AC OCC
	Stat	e	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	psyl	ere, M	gulp-9	3/2/3	S
R	egistra		DEC 0 2 2009 Setus	A. 400	Mal				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Elizabeth Rock Jane \mathbf{P}^{M} November 23,2009 1:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson
If Under 1 Year Baltimore Greater Baltimore Medical Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 4 1916 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 209 10 3957 Johnstown, PA Director Usual Residence of Decedent 10d. Inside City Limits works 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medical Event. 1 ☐Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIIo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2√√XNo Specify: ģ XX Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Line Worker Bendix 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert J Tompkins Mary Friedel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene L. Rock 207 South Shaffer Drive New Freedom, PA. 17349 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. November 25 2009 Baltimore, Maryland 4☐Donation 5☐Other (Specify) 21. Śig 22. Name and Address of Facility Lassahn Funeral Home Inc atu e of Funeral Service Ucensee 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final troke **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1∐Yes 2 No Ö been signed by the should be detached 9 Hinknown 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed Yes 2 No certificate 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 2XER/Outpatient 3 DOA ပ 1 Inpatient this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident in by the Director; 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after filled within 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) N. Charles St Touson 21204 iams 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician YLILT ABRAH Druc, 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SECOURS BUN 3AUTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F Director Maryland Feb 14, 1950 215-56-1570 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 1 XYes 2 No Director Harve De Grace Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21078 U.S.A. 1128 Chesapeake Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 2 Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital / Nursing Home LPN 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Riley Abraham Riley ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1128 Chesapeake Drive - # 14C Harve De Grace, Maryland 21078 Alice Riley 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 12/7/09 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 or complications that caused the death, bo not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. SED SIS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): FNEWWON'H Examiner BILH TERAL Se prentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine RENAL DISEASE STAGE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 HISTORY CARDIOMYDPATHY; 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HIU POSTTIVE; CONGESTIVE HEALT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No FAILURE, HEMOCATH 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be

e Hospital or Attending Physician: he law requires that the death certificate be executed 24 hours attendeath.

24 hours attendeath.

25 Funeral Director: After this certificate has/en signed by the attending physician and letely filled in by the funeral director, pge 2 knowld be detached for use as the burial-transit P.O. Box 68760 Division of Vital Records, within 24 hor To the Fune completely fi

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show

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number mognoch, mo

29d. Date signed (Month, Day, Year)

and manner stated

11/20/20019 114949 JUN W. ASTUTIONE STREET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V.

BALTIMONE, MD 31733

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOV. 9 23^{ay} 2009 Emily A. Rogers : 30 pm Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Franklin Woods Nursing Center Rosedale Baltimore 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year 918 Days Hours June 14 219-03-1771 Months Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Director MD Baltimore Essex 1 Yes 2X No 10e. Street and Number 23a or 2 10f. Zip Code 10g, Citizen of What Country? Funeral 515 Delaware Avenue 21221 USA items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify White "natural", 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Jacob Schwinn Marie Herfel injury or other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 William Rogers /son 2106 Southhill Court Belair MD 21015 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or otl Date cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State OAk Lawn Cemetery 11/30/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD <u>Connelly Funeral Home of Essex</u> 23a. Par 1. Enter the disease, or shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an after death. Director: After this certificate has page 2 autopsy performed Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **%**No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury **™** Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation npleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

e Funeral I the within To the

State

Registrar

(Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D53465

29d. Date signed (Month, Day, Year)

2106

29c. License number

JUde

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dolores Reisig November 26, 2009 12:30 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4520 King George Ct Perry Hall Baltimore 8. Date of Birth (Month, Day, Year) Jan. 3, 1919 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Social Security Number 1 □ M 2 🕸 F Months Min. Days Hours 90 Yrs. 220-03-1489 MD Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov 1. ☐Yes 2 XNo Director MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 4520 King George Ct USA by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pagas 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Jones. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Bussells Mamie Woods ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4520 Kinge George Ct Perry Hall, MD 21128 Mary Kraus-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 11/30/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc 6415 Belair Rd Baltimore, MD 21206 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the daath certificate be executed attanding physician and for use as tha burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No P.0. certificata has been signed by than ractor, page 2 should be datached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋧ 1 Tyes 2 No 3 Probably 4 Hriknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 🗆 No funeral diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOVEMBER 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE NO 21202 27 ST MAUZ filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 10 NUP 28, 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner General 1 Near If Under 24/Hrs. HMOVE Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M M 2□ F Months Days Hours Min. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Exante er must be retified at Director 1 XYes 2 □ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 "natural", 3 ☐ Widowed 4 🛱 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P ٩ DMI 19a. Informant's Name/Relationship (Type. Print) riend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, ate, Zip Code) S Department of Health Important: If item 27 any Injury or other troone. en 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) National nore 22. Name and Address of Facility
Joseph L. Russ
222 W. North 21. Signature of Fun, ral Service Licensee W. North Ave. Balto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10,5514 Introcranca disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0 X2515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of The law requires that the death certificate be executed for use as the burlal-trans Monary and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. s been signed by the sahould be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has bage 2 s autopsy perform Vital F certificate 2 No 1 □Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō 27. Magner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Madrid Maryland General 40 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

09-09257 Robert Shock Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Expension Robert E. Shock, 111 de	Physician/	1- For State Registrar 1. Decedent's Name (First, Middle,Last) Certificate of Death Reg. No	3. Time of Death						
304 Melanothon Avenue Section Service Number Section Service cal Examiner									
218-70-6329 TM 2		304 Melanchton Avenue Lutherville Timonium	Baltimore County						
The State of County of the Cou		$218-70-6329$ $_{1}$ $_{M}$ $_{2}$ $_{F}$ $_{57}$ $_{7rs.}$ $_{Months}$ $_{Days}$ $_{Hours}$ $_{Min.}$ $_{April}$ $_{20}$,							
30.4 Mel anchton Avenue 21093	*	10a. State 10b. County 10c. City, Town or Location							
The state of the place of the p	h the Maryle 3a or 28a-f otified at or	304 Melanchton Avenue 21093 US	-						
The state of the second program of the secon	ter death wit ", or items 2 er must be n r Funera	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc. White						
The second of the place of the special program of the second of the place of the special program of the place	n 72 hours af	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Linemployed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Kind of Business/Industry						
The state of the second program of the secon	se filed within trial Hygiene. ked other then the Med See Comp	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maidel	n Surname)						
22. Name and Address of Facility Towson, Maryl and 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Approximate interval between the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. The mediate Cause of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart mediate Cause of complications that caused the death. Dash of the feature of the fea	nd 2 should I alth and Mer m 27 is mar aumatic eva	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 222 Ridgely Road Lutherville, Maryland							
Approximate interval Approximate interval	Deficiency of permit. Pages 1 at Department of Hee Important: If ite injury or other tr	Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 12/1/2009 7	owson, Maryland						
The failure. List only one cause on each line. Failure. List only one cause on each line. Between Onset and Death Deat	permi Depar Impo injury	Ruck Towson Funeral Home, Ir	ic. 1050 York Road						
Sequentially list conditions, if any, leading to immediate conditions, countribute to great any of the country that imitated covers resulting in death). Last of the country that imitated covers resulting in death). Last of the country that imitated covers resulting in death). Last of the country that imitated covers resulting in death). Last of the country that imitated covers resulting in death). Last of the country that imitated covers resulting in the underlying cause given in Part I. Due to (or as a consequence of):	Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Cardiovascular Disease	Between Onset and						
UNPENDED UNPENDED AMENDED AME	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
Second of the composition of t	ecuted and transit	events resulting in death) Last Due to (or as a consequence of):							
Was decedent pregnant in the past 12 months? Was 2 No 9	nte be ex hysician e burial -		3d. Date of delivery						
Part of the control o	eath certifica e attending p for use as th	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)							
29c. License number O.C.M.E. November 29, 2009 November 29, 2009 Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	res that the d signed by the be detached d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
29c. License number O.C.M.E. November 29, 2009 30. N = and ddress of person who co red cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	he law requi	autopsy performed?	prior to completion of cause of death?						
29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 29, 2009 30. N e and ddress of person who come ed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ian: T certifica cctor, pa	25. Was case referred to medical 26.Place of Death (Check only one)							
29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 29, 2009 30. N e and ddress of person who come ed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Physic er this ral dire	1 ▼ Yes 2 No Indignation 2 ER/Outpatient 3 DOA One 4 Nursing Home 5 Resid							
29c. License number O.C.M.E. November 29, 2009 30. N e and ddress of person who come discussed death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Attending r death. extor: Aft by the fune ication:	1 V Natural 5 Pending (Month, Day, Year) 1 Yes 2 No Investigation (Month, Day, Year) 28e Place of Investigation (Street Factors of Investigation (Street Factors of Investigation (Street Factors of Investigation I							
29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 29, 2009 30. N e and ddress of person who co red cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Hospital or 24 hours afte Funeral Di tely filled in al Certif								
O.C.M.E. November 29, 2009 30. Note and ddress of person who come ed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To the within To the comple	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pand manner stated.							
Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		MM CAMAN O.C.M.E. NO							
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	'(V								

		For State Registrar	State	of Marylan		artment rtificate			nd M		giene Reg. No.		-		
Physicia		1. Decedent's Name (First, Mide	, ,							Date of De Month	ath Day	, 2 U	ear 9	3. Time of	B-3n4 5
/Medica		Rhea Lou Scho		ımher)		4b. City, To	own or L	ocation of		lovembe		County of	009 Death	5:15	a '''
Examine	r	Cherry Lane Nu	-			Laure	_				1	ince		rae	
Funeral Director		5. Social Security Number 273-40-1082	6. Sex 1 ☐ M 2 🗗 F	7. Age (In yrs.	last birthday) 71 Yrs.	If Under 1	Year	If Under 2 Hours	Min.	8. Date of Bird (Month, Da June 1	th y, Year)	9		lace (State	
P		Usual Residence of Decedent		140- 00	Tana										
Marylar	ģ	10a. State 10b. Count MD Prince	y e George	Lau	y,TownorLo rel	cation							11	0d. Inside C 1	ity Limits 2⊠No
h the	lec	10e. Street and Number		25.5		10f. Zip (Code				10g. Citi	izen of Wha	at Coun	try?	
th with sith sith sith sith sith sith sith s	<u>a</u>	9001 Cherry L	ane			2070	8				USA				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1XXNever Married 2 Ma 3 Widowed 4 Divorce	Armed F 1 ☐ Yes if Yes. G	2 ∕∏√ No iive		Was Decede if Yes, speci 1 □ Yes 2,		panic Orig , Mexican, Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		14. Race - Black, Specify:	White,	etc.	
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental hygiene. 77 is marked other than "natural", or traumatic event, the Medical Examit	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education est grade completed College) (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done dui retired)	ring most	of workin	ng	16b. Ki	ind of Busir	ness/Ind	lustry	
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Mary and 2 shot salth and N 27 is ma		19a. Informant's Name/Relation		other						Route Numb	-				34228
Saltimore, bermit. Pages 1 at Department of Hee mportant: If Item my Injury or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other		n State '	Place of Dispo cemetery, cre- aron G	sition (Name matory or oth	e of ner place))		ate 1,	20c. Lo	ocation - Ci	ty or To		
Baltii Permit. B Departm Importar any Injur		21. Signature of Funeral Service A Kein Stille		MOl	2	2. Name and	Address	of Facility	y Don	aldson aurel,	Fun	eral		e, P.F	A.
Physician		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause on	each line.	th. Do not en		of dying,	such as	cardiac o	r respiratory a	rrest,			Approxima Interval Be Onset and	etween
/Medical Examiner		disease or condition resulting in death)	Due to	(or as a consec			PX=7	rec	M	PLLITI	is				
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8760, cate be executed by sician and the burial-transit		that initiated events 'resulting in death) Last	c. Due to	o (or as a consec	quence of):										
687 rtificate ng phys as the	led led														
Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐Live	utcome pf pregn birth 2 Feta gnant at time of a nown	al death 3	Ectopic pre Other (spe						23d. Date (ery Day	Year
cords, P w requires that been signed b should be deta		Part II. Other significant condi		death but not res		nderlying ca	use given	in Part I.				use contrib		ne cause of pably 4 🛭	death? Unknown
Division or Vital Records, for Attending Physician: The law requires t after cleath. Director: After this certificate has been signe in by the funeral director, page 2 should be	Completed by									24a. Was auto perfo 1∐ Yes	psy ormed?	pri de:	ere auto or to cor ath?]Yes	psy findings mpletion of	s available cause of
Vital I	Be	25. Was case referred to medic examiner?						26. Place	of Death	(Check only					
Or \	2	1 ☐ Yes 2 ☑ No		Inpatient 2				4 🖭 Nui		ne 5□Resi				y)	
Division or Vital or Attending Physician: the death. Director: After this certifical in by the funeral director.	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves	ling (Mo	e of Injury onth, Day Year)	28b. Time of Injury	M 28	lc. Injury a Work? 1 ∐ Ye	at es 2∐1		28d. Describe	how inju	ry occurred	1		
Division all or Attend a after death.	ertifica	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	rminod Zoe. Plac	ce of injury - At h ding, etc. (Speci	ome, farm, st	reet, factory,	office		2	28f. Location (City or To			or Rura	l Route Nu	mber,
Division or Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	29a. Certifier 1 ☐ Certify (Check only one) 1 ☐ Certify 2 ☐ Medic	ring Physician: To the all Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	th occurred anvestigation,	t the time in my opi	e, date an inion, dea	nd place, a	and due to the ed at the time	cause(s , date an) and mani d place, ar	ner as s	tated. the cause	(s)
To the within 2 To the complete	M	29b. Signature and title of certif	fier /				License	number 596	49			ate signed (
81		30. Name and address of person Ikechukwu D. Mi					Rd.,	Suite	e 30	2,Ellia					2
Stat Registra		31. Date filed (Month, Day, Yea		Registrar's Sign		arked									

DHMH 17 Rev 1/2001

		,	1 _ State	artment of Health and Me		ne .no. 2009 38346
			Registrar 1. Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death
	Physicia		Eleanore Schissler	N	ovembe	r 27,2009 9:35p M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
and the			Riverview Care Center	Essex		Baltimore Co.
	Funeral		5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday,	Months Davs Hours Min.	. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		218-54-2158 1 M 280 89 Yrs. Usual Residence of Decedent		-21-19	20 Maryland
	yland		10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits
	e Mar	ctor	MD N/A Balti	more		1 X Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	s 23a	eral	229 S. Washington Street	21231		USA
	ter de item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric	oan, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show diget Experiment be notified at	þ	If Yes, Give 3 ☑ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: White
2-0	72 ho natur	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16	b. Kind of Business/Industry
121	vithin ane. :han "	dm	Elementary/Secondary (0-12) College (1-4or 5+)			HOME
d 2	filed v Hygie ther i	ပိ	6 N/A H 17. Father's Name (First, Middle, Last)	lomemaker 18. Mother's Name (F	First, Middle, Mai	
lan	ld be fentai ked o	To Be	Julius Zarachowicz			(UNK)
ary	shou and N s mar	۲		ing Address (Street and Number or Rural F	Route Number, C	City or Town, State, Zip Code) 21222
Σ	and 2 ealth n 27 I					Apt 417 Dundalk,MI
ore	ges 1 t of H if Iter or oth			osition (Name of matory or other place)	09	c. Location - City or Town, State
Baltimore,	t. Pac rtmen rtant: njury		4□Donation 5□Other (Specify) Sacred	Heart of Jesus C		Dundalk, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once.			2. Name and Address of Facility Racz 201 Dundalk Aven		i Funeral Home, PA timore, MD 21222
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or r	espiratory arrest	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)			a Pendays
1	/Medical Examiner		Due to (or as a consequence of):			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	cuted nd ransit	Examiner	that initiated events c.			
000	cate be executed physician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical	d			
Box 6	eath certific attending p	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
	death e attel d for u	iciar	in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.0.	at the by the	hys	9 ☐ Unknown			
ŝ	law requires that the d as been signed by the 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		cco use contribute to the cause of death?
ord	requii	ted	afrial Librillation		1 L Yes	2 No 3 Probably 4 Ahrknown
3ec	e las	Completed by	deventa		24a. Was an autopsy performe	d? 24b. Were autopsy findings available prior to completion of cause of death?
la	iclan: The I certificate ha ector, page	ပ္ပ	hypo typoto 25. Was case referred to medical	00 81 48 44	1 □ Yes 2 🛭	
<u>=</u>	ysicia is cert directo	o Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (ce 6 ☐ Other (Specify)
J Of	Attending Physician: If death. ector: After this certific by the funeral director, I	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. T		d. Describe how	
Sior	vttendin death. ctor; Af y the fur	atio	2 Accident investigation	M 1 □Yes 2 □No		
Division of Vital Record	To the Hospital or Attending Physician: The within 24 hours after death. Othe Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28	f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	spital hours neral y filled		29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, dea			
	the Ho hin 24 I the Fu mpletet	edical	(Check only one) 2	nvestigation, in my opinion, death occurred	at the time, date	e and place, and due to the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
				D19667		ovember 30, 2009
			30. Name and address of person who completed cause of death (Item 23a) (Type Michael Schwartz, M.D. 7310 Ri			len Burnie arvland 21061
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	and I my. butte	700 M	aryrand ZIOUI
	Registr	ar	31. Date filed (Month, Day, Year) DEC 0 2 2009 32 Registrar's Signature A			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

4b. City, Town, or Location of Death

BALTIMORE

Month

NOV.

Day

27

Year

2009

BALTIMORE

14. Race - American Indian Black, White, etc.

Specify:

DOCTOR

23d. Date of delivery

Dav

2 No 3 Probably 4 Unknown

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

Year

Month

WHITE

4c. County of Death

38347

 A^{M}

3. Time of Death

1:20

Birthplace (State or Foreign Country)

MD.

10d. Inside City Limits

1 □ Yes 2 □ No

21224

Approximate Interval Between Onset and Death

1	Physicia /Medic Examin	al
ı	Funeral Director	

For State Registrar

JULIA

Μ.

4a. Facility Name (If not institution, give street and number)

FUTURE CARE NORTH POINT

THORWEGEN

8. Date of Birth (Month, Day, Ye. MARCH 24, If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 85 Months Days Hours Min. 213-20-9942 1 □ M 2 🛛 F Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at Director BALTIMORE PERRY HALL MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 31 LINCOLNWOODS WAY APT 1C 21128 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify <u>۾</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL SECRETARY 12TH 0 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 Is marked other i any injury or other traumatic event, II. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JULIA AGNES ONION WILLARD J. BURNS ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1890 EMILY DRIVE, EDGEWOOD, MARYLAND ALFRED_LANE/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 11/30/09 BALTIMORE, MARYLAND 4 Donation 5 DOther (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licenses 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a. Part 1. Enter the diseas shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) JYes 2 □ No signed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 24a. Was an has autopsy 1 ☐ Yes 2 Ø No Division of Vital e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2. and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date sighed (Month, Day, Year) sum wards food. M1) 21234. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8913 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

DEC 0

DHMH 17 Rev 1/2001

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Maryla		tificate of L			gierie Reg. No.	_
Physic	ion/	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ath ZU	0 \$3. Timeofoeatt 4
Med			JNITE				Novembe	er 28 200	9 9:10 PM
Exam	iner	4a. Facility Name (if not institution, give			4b. City, Town, or Bowie	Location of Death		4c. County of D	
Funera	al	5. Social Security Number 6. Se	ex 7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h g.	George's Birthplace (State or Foreign
Directo		219-83-4343	XXM 2□F	56 Yrs.	Months Days	Hours Min.	(Month, Day Feb. 1	5, 1943	Country) Philippines
nd how	٦	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation				10d. Inside City Limits
Aaryla 8a-f s tified	Director	MD Prince	George's	Bowie					1 ☐ Yes 2 🛣 No
a or 2 be no	ig D	10e. Street and Number			10f. Zip Code		T	10g. Citizen of What	Country?
th with ns 23 must	Funeral	9301 Crutchfield			2072			US	SA
r dear		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2XXNo	U.S. 13. W	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
036 rs afte	ed b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🗓 No	Specify:		Specify: P	Asian
21215-0036 within 72 hours after giene. ier than "natural", o	Completed by	15. Decedent's E (Specify only highest gra		(Give k	ent's Usual Occup	ation during most of work	ing	16b. Kind of Busine	ss Industry
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illed w Il Hyg I othe	Be	17. Father's Name (First, Middle, Last)			1	18. Mother's Nam	e (First, Middle,		repair ellierre
ylar Id be i	6	Segundino Uni	te			Maria	De La	Cruz	
Maryland 2 should be filed the and Mental Hy 27 is marked oth		19a. Informant's Name/Relationship (T)						, City or Town, State,	Zip Code)
and 2 s Health tem 27		Mae A. Unite/Spor		930. b. Place of Dispos		nfield La	ne, Boy	wie, MD 2 20c. Location - City	20720
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	cemetery, crem	del Crem	e)	0/2009	Odenton,	
Baltil permit. F Departm Importa any inju	ġ	21. Signature of Funeral Service Licens						Funeral H	
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		23a. Part 1. Enter the disease, or company shock, or heart failure. List only o	plications that caused the denie cause or each line.	eath. Do not ente	r the mode of dying	g, such as cardiac o	or respiratory arr	est,	Approximate Interval Between
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8760 ifficate boild physical as the b	cian/Medical	IF FEMALE;	u						
th cert	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live Birth 2 F	etal death 3	Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
P.O. Box 68 that the death certined by the attendine e detached for use a	Physic	1 Yes 2 No 9 Unknown	4 Pregnant at time	of death 5 🗆	Other (specify)			Widitii	Day leal
P.O.	by Pt	Part II. Other significant conditions co	ontributing to death but not	resulting in the ur	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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of Vital Rec Physician: The law r this certificate has aral director, page 2		25. Was case referred to medical					1 Yes	rmed? death 2X No 1	Yes 2 🗓 No
/ita	To Be	examiner?	Hospital:	□ EB/Outpotion	_ Othe	ace of Death (Checker:		ence 6 Other (Sp	
of \ g Phy er this heral c		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury	at at		ence 6 LI Other (Sc ow injury occurred	весту)
ion eath. or: Aft	fical	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be) injury	M 1 🗆	Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director After this certificate has been signed in by the funeral director, page 2 should be in by the funeral director, page 2 should be a sh	I Certificate:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe		et, factory, office		28f. Location (S City or Town	treet and Number or i n, State)	Rural Route Number,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exami	sician: To the best of my knoner: On the basis of examina se Practioner: To the best of	ation and/or investi	gation, in my opinio	n, death occurred at	the time, date ar	nd place, and due to the	ne cause(s) and manner stated.
To the company		29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo	nth, Day, Year)
6		Moster	Mehru			50514		11/3010	5
_ J V		30. Name and address of person who of Mehru Master,	completed cause of death (It			ce 100, R	iverdal	e, MD 207	37
St Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		1 .0 6				
DHMH 17 Rev 7	_	<u>ner 6.5</u>	Chreva	1. A.	bartled				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 228 WAR 2009 December /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death General etimore Maryland 8. Date of Birth (Month, Day, Year) 02/04/1924 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1**X**M 2□ F Hours 213-16-6490 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Inductant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 1XYes 2 No Funeral Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number U.S.A. PLACE 21217 1802 EUTAW 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married コッカハ しのドイド/ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNK Elementary/Secondary (0-12) College (1-4or 5+) LINK UNK 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) UNK Be ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARETAKER EUTAW PIACE, BALTIMORE, MARY AND 21217
sition (Name of Date, Date, 20c. Location - City or Town, State CAMINE MATTHEWS 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 102 2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The DERRICK C. JONES FIH, 8.4. 21. Signature of Funeral Service Licensee 4611 PARK HGTS AVE. BALTIMORE, MARY land 21215 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final ailure **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Pheumon 1a 4 D Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 12 No 1 ☐ Yes 2 ☐ No 1 □Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 W Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 🖟 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar General Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

COUGITY BROWN

32. Registrar's Signature

H0064267

Linder Hu. Balt 410. 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day November 27 eresa 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Days Hours 1 □ M 2 💢 F 246-33-8152 09 29 NC 68 41 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No Edgewood MD Harford 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number U.S.A. 21040 1300 Harford Square Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 Yes X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Disabled Disabled 12th grade 6yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Esther Connally George Warren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type. Print) 110 Brooksbury Drive #1C, Reisterstown, Md Esther Connally-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) Prospect Hill 12/01/2009 Roxboro, NC 22 Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md Signature of Juneral Service Liger 21215 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Dickte disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cluss. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 TEctopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Department of Health ar
Important: If item 27 is
any injury or other trau
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Director

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Completed

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

29b. Signature and title of certifier

Michae

31. Date filed (Month, Day, Year)

injury or other traumatic event, the Medical Examiner must be notified at

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and nding physician the as or Attending Physician: after death. after death. filled in by the

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☒No 3 □ Probably 4 □ Unknown							
		24a. Was an autopsy performed? 1 Yes 2 No 1 Vere autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No							
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 Yes No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursi	ng Home 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death ↑★Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred							
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
On Continue 18 Continue Ph	relation. To the heat of my knowledge, death accurred at the time, date and	place, and due to the cause(s) and manner as stated							

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2000

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silve Registrar's Signat

and manner stated.

24 hours Hospital

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38353 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29^{Day} Physician/ Dorothy J. Woods Novanth 2009 3:50pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Essex 249 Sandhill Road Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 1 □ M 2 😾 F March 16, 1925 218-48-4826 84 Director Usual Residence of Decedent and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director Essex Baltimore MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 249Sandhill Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 6th College (1-4 or 5+) Page 1 and 2 should be filed within own home Homemaker Be 18. Mother's Name (First, Middle, Maide Pauline Clowe 17. Father's Name (First, Middle, Last) Robert Frank Seymour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 249 Sandhill Road permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Baltimore MD 21221 Richard Woods / 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date M Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 12/1/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Connelly Funeral Home of Balto. MD Essex 21221 Signature of uneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner years Sequentially list conditions, if any, isaming to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Die to for as a nor sequence of attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed a Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death certificate has been signed by the attendin rector, page 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 1 Natural work 5 Pending efter death.
Lirector: After din by the fur 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours e Funeral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) Signature and tit AHENDINAMD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

on who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signatur

Nov 30 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) : 18 A M **Physician** SYLVIA WEINBERG 29 2003 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A OF BALTIMORY BALTIMORE MOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NY 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 05-04-1920 Days 1□M 2X F 213-34-5893 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No 7 Is marked other than "natural", or items 23a or 28a-f si traumatic event, "na Madical Experiment in that by matthed Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 21215 USA 3211 CLARKS LANE. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No WHITE Specify: <u></u> 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatic event, I'm Madagonce. Elementary/Secondary (0-12) College (1-4or 5+) SWITCH BOARD OPERATOR LEVINDALE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MORRIS BERMAN LENA YOUNGMAN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EDWARD LEVENTHAL/SON 6315 PEARCE AVENUE, BALTIMORE, MD 21215 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of MIRE PROPERTY LEGISTRES OF other place)
BETH ISRAEL 20c. Location - City or Town, State 12-01-2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licensee, 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** erebella disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No o 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Brinder SKANDA.

OF BALTIMARA

29c. License number

RES 000

2401 w Belvedor Au

29d. Date signed (Month, Day, Year)

November 29, 2009

Rellimore, MO 2121)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai MOSPITAL

			For	State of Ma	ryland / Dep	artment of H	Health and I	Mental Hygi	ene	
		•	State Registrar		Ce	ertificate of	Death	Reg	9. No. 2000	38355
	Physicia	an	1. Decedent's Name (First, Midd	,				Date of Death Month	Day Year	3. Time of beath
	/Medic	al	Chuen Shek 4a. Facility Name (If not institution			Ah City Town o	or Location of Death	Nov. 19,	2009 4c. County of Death	3:50p M
	Examin	er	8105 Owens Way			Brandyv			Prince Geo	orge's
F	uneral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday			8. Date of Birth (Month, Day,	9. Birthr	lace (State or Foreign
Di	irector		212-75-3411	X M 2□F	83 Yrs.	Months Days	Tiodio IVIIII	Feb. 19	,1926 China	
land	WO III		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or L	ocation.			1	0d. Inside City Limits
Mary	1-f show	tor	MD Pri	ince George's	Brandy	wine				1 ☐Yes Ž No
th the	or 28e	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Cour	ntry?
ath wi	3 23a		8105 Owens Way			20613			China	
er de	items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Mai	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No		. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puert	pecity Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
urs aft	al", or	þ	3 ☐ Widowed 4 ☐ Divorce	If Yes, Give		1 □Yes 2 XNo	Specify:		Specify: Asia	an
of 2 12 13-0000 filed within 72 hours after death with the Maryland Hydiene	natura lical i	Completed	15. Decede	nt's Education est grade completed)		edent's Usual Occup re kind of work done			6b. Kind of Business/In	dustry
ithin a	han ")du	Elementary/Secondary (0-12)	College (1-4or 5+	·) life.	DO NOT use retire	nd)		al- '	
Filed v	ther t		17. Father's Name (First, Middle	. Last)		Sailor	18. Mother's Nan	ne (First, Middle, Ma	Shipping aiden Surname)	
d be	ked o	To Be	Unknown	,			Unknown			
should be	T is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examinar must be notified at	-	19a. Informant's Name/Relation	ship (Type. Print)	19b. Mai	ling Address (Street		ıral Route Number,	City or Town, State, Zip	Code)
≥ =				Sang Wong, So		Owens Wa				
Pages 1	Important: If item 2 any injury or other once.		20a. Method of Disposition 1 N Burial 2 ☐ Cremation	3 ☐ Removal from State		oosition (Name of ematory or other pla			Oc. Location - City or To	
it. Pa	rtant		4 □ Donation 5 □ Other (2)			Cemetery 22. Name and Addre			alhalla, NY	
Der Per	any ir		139 1)	, cicerisee 1. Ha		41 Canal			Funeral Ser NY 10002	vices, LLC
			23a. Part 1. Enter the disease, or heart failure. Lis	or complications that caused at only one cause on each line	the death. Do not e					Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	END S	TAGE	Luna-56	vamou	is cell	2	Onset and Death
	edical miner		resulting in death)	Due to (or as a	consequence of):	/				west
LAC	maner	7	Sequentially list conditions,	b. Theore	consequence of):					week
uted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 Rena	1 fail	ore			h.	week
e exec	sician and buriat-transit		resulting in death) Last	Due to (or as a	consequence of):					11.
The law requires that the death certificate be executed	the la	dical		d Hype	-tensi	N				45
Sertific	attending p for use as	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date of deliv	ery.
leath i	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at	2 Fetal death 3	B ☐ Ectopic pregnan	су		Month Month	Day Year
j eg	been signed by the should be detached	hysi	9 Unknown	9 Unknown						
es tha	gned oe det	by P	Part II Other significant condit	ions contributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.		acco use contribute to t	
requir	seen s nould		Hyper Kal	emia, 100	recyc	10313		1 Q Yes		bably 4 ☐ Unknown
e law	has e 2	Completed	dysphag	16				24a. Was an autopsy perform	prior to co	opsy findings available empletion of cause of
ا با ا	certificate rector, pag		25. Was case referred to medical	al I			00 Plans of Day	1 □ Yes 2	No 1 □Yes	2 N o
ysicia	s cert directo	To Be	examiner? 1 Yes 2 No	Hospital:	nt 2 ☐ ER/Outpati	ient 3 DOA Ot	hor:	ath <i>(Check only one</i> Home 5 Resider	nce 6 □ Other (Speci	ifv)
2 E	fter th	n:T	27. Manner of Death 1 ■ Natural 5 □ Pendi	28a. Date of Injur (Month, Day	ry 28b. Time			28d. Describe how		-
tendir Path	or: A the fu	catic		tigation		M 1 []Yes 2□No			
or At	Direct in by	ertification:		mined 28e. Place of Inju building, etc	ry - At home, farm, s . <i>(Specify)</i>	street, factory, office		City or Town,	eet and Number or Rur State)	ai Houte Number,
Hospita 24 hours	To the Funeral Director: After this certified completely filled in by the funeral director, p.	edical C		ing Physician: To the best of al Examiner: On the basis of and manner sta	examination and/or					
To the	To the	Me	29b. Signature and title of certific	er Reille	es me	29c. Licen	se number	+9 /	Date signed (Month)	2009
5	$\sqrt{}$		30 Name and address of perso	nywho completed cadse of ac	eath (Item 23a) (Typ	Print) bas	e Ave,	1-1,4	nepelici	KMP21701

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38356 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Ye ar **Physician** Myra Worrel 5-37 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmace
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Center Medica 8. Date of Birth Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🜠 F 214-38-6528 Director lary land Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. Count items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner rust be notified at 1 Tes 2 No Funeral Director 17 more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2 No Specify Specify: Black Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Educ 12 leacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ 19a. Informant's Name/Relationship (Type. Print) dunght 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. 2221 1100 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State tark and Address of 21. Signature of Funeral Service Licenses Name 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.0. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 1 Inpatient within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 □Yes 2 □No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11/28/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Paul

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any follury or other traumatic event, If a Madical Evantinar must be notified at once.

attending physician and for use as the burial-trar certificate has been signed by the rector, page 2 should be detached ours after death.

eral Director: After this certific filled in by the funeral director,

Be Completed by Physician/Medical

Medical Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year					
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	e. Did tobacco use contribute to the cause of death?					
Hypertipoden	NA	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown					
Hayporting void		a. Was an autopsy performed? Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No No No No No No No					
25. Was case referred to medical examiner?	26. Place of Death (Checi	k only one)					
examiner? 1 ☐ Yes 2*▼No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day, Year) Injury Work? n M 1 ☐Yes 2 ☐ No	scribe how injury occurred					
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At nome, farm, street, factory, office 28f. Loc	ation (Street and Number or Rural Route Number, y or Town, State)					
29a. Certifier (Check of one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							

29c. License number

29d. Date signed (Month, Day, Year)

TOWSON, MD 21204

State Registrar 31. Date filed (Month, Day, Year) DEC 0 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29b. Signature and title of certifier

MI

DHMH 17 Rev 1/2001

24 hours a within 24 ho. To the Fune completely fil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EDNA ROSE ANDREWS 0250 Medical Novembe 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death aston at Easton Talbot Isinoma **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2X F Hours JUNE 4, 1939 MARYLAND Director 217-36-2433 70 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND TALBOT MCDANIEL 10f. Zip Code 10g. Citizen of What Country? Funeral 9745 TILGHMAN ISLAND ROAD 21647 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. . Edna 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give ⋧ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) 11 WAITRESS FOOD SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM GEORGE JOHNSON ROSE ELIZABETH HADDAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILSON W. ANDREWS/HUSBAND PO BOX 125 MCDANIEL, MD 21647 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) NEAVITT CEMETERY NOV.17,2009 NEAVITT, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 3 MERCER 200 SOUTH HARRISON ST EASTON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancu ancientic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate sician and burial-transit Exami that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Yo Month Year Day Pregnant at time of death signed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Movembe 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 LAKSHMI VAIDYANATHAN, 505 B DUTCHMAN'S LANE MD EASTON, MD 21601

Registrar
DHMH 17 Rev 7/2009

State

31, Date filed (Month, Day, Year)

NOV 10

10f. Zip Code

21652

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

9. Birthplace (State or Foreign

10g. Citizen of What Country?

14. Race - American Indian, Black, White, et

White

USA

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Year

Month

1 Yes

21601

1 Yes 2 No

10c. City, Town or Location

Neavitt

Funeral

Physician

/Medical

Examiner

5. Social Security Number

10e. Street and Number

10a, State

Md

219-36-5728

1 Never Married 2 Married

10b. County

Talbot

6447 Bozman/Neavitt Rd.

Usual Residence of Decedent

1**∑**M 2□ F

Director

with the Maryland or 28e-f ahow 27 is marked other than "natural", or Itams 23a or 28e-f abov traumatic evant, the Medical Examinar must be notified at permit. Pages 1 and 2 should be filed within 72 hours after death with Dependment of Health and Mental Hygiene. Important: if I tam 27 ie marked other than """ any Injury or other traumer!" any Injury or other traumer!"

Physician /Medical **Examiner**

Hospital or Attanding Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit P.O. Box 68760 Division of Vital Records, his After this funeral c death. nours after death, ners! Director: A filled in by the fi

10+ VA

State Registrar

David H. Smith, 31. Date filed (Month, Day, Year)

Funeral Director 12. Was Decedent Ever in U.S. Armed Forces? M∏Yes 2 □ No If Yes, Give AIT FC. Year or Dates: 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) Civil Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore Allen Sarah Murray 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Jones Allen 6447 Bozman/Neavitt Rd. Neavitt, Md. 21652 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/7/2009 Cambridge, Md. Mid Shore Cremat 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC P.O. Box 518, St. Michaels, Md. 2 Joseph M. Estauski S.P. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Onknown autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Mannet of Death 28b. Time ot 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

8221 Teal Dr. Easton, Md. MD 32. Registrar's Signature

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

NOV 0 6 2009

within 24 hours a To the Funeral L

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38360 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November 25 2009 10:22 P M Miriam Orsena Angleberger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov. 18, Year 1920 Days 1 M & XX Months Hours Min. Marviand 89 218-50-4392 Director e filed within 72 hours after death with the Maryland that Hyglene.

at al Hyglene at a factor of the state of 28a-f show event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗆 Yes 2 🔀 No Braddock Heights Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4714 Schley Avenue 21714 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Black, White, etc. 11. Marital Status Armed Forces?

1 Yes XXX No
If Yes, Give
Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: White 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hench Ezra Hester Irene Feaga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 423 Quaker Hill Road, Union Bridge, MD 21791 Edgar M. Angleberger, son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State or other place Mount Olivet Cemetery Nov. 30, 2009 Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li, e 22. Name and Address of Facility Keeney and Basford PA Funeral Hone 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician, erlinsine disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a donsequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier

e Hospital or Attending Physician: The law 124 hours after death.
e Funeral Director: After this certificate has t

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) d title of certifier 29b. Signature as 29d. Date signed (Month, Day, Year) MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Kaufmann, M.D., 300 West 9th Street, Frederick, MD 21701

State Registrar

DHMH 17 Rev 7/2009

Th

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year) November 22, 2009

30. Name and address of person who completed cause of death (Item 23a)

Victor Weedn MD JD

31. Date filed (Morbie

Ver

Assistant Medical Examiner

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month November 10, 2009 Raymond Bradley 11:00P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 XM 2 □ F Days 365-62-5620 Nov. 11. 1955 Michigan Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 20748 3103 Good Hope Avenue, Apt. 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes X☐ No Specify Specify:Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Belle Fanie Lee Bradley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Lewis/Sister Benton Harbor, Michigan 49022 663 Eloise 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-30-09 LaPorte, Indiana Mid West Crematory 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 6009 Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): munical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 🗆 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Funeral Director

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Completed

Be

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Examiner

Funeral

Director

id other than "natural", or items 23a or 28a-f event, the Medical Examiner must be notifi-

'natural",

I Hygiene.

ilth and Mental Hygier 27 is marked other the traumatic event, the

Department of Health a Important: If item 27 Is any Injury or other trau once.

with

1 and 2 should be filed within 72 hours after death

Pages 1

altimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending Physician:

r death.

certificate has

After this

Examiner attending physician and for use as the burial-transit Physician/Medical ò Completed page 2 funeral director, Be

Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Medical

23b. Was decedent pregnant

1 ☐ Yes 2 11No 27. Manner of Death 1. Natural

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

MD

28b. Time of

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

AHMED

MD

29a. Certifier 29b. Signature and title of certifier

2 ☐ Accident

4 Homicide

3 ☐ Suicide

29c. License number D0060100

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 11-11-09

2090

3 State Registrar

8 Universit 31. Date filed (Month, Day,

BLID 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMIN A

Soust SILVEY Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:30P M 2009 Nov. 16, /Medical Ernest Biser 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1088 Turkey Neck Road Swanton Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Director 220-16-5541 June 7,1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinst must be notified at Director 1 ☐ Yes 2 📉 No MD <u>Garrett</u> Swanton 10e. Street and Number 10g. Citizen of What Country? 'natural", or items 23a U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Modical Examinschaust pages. Funeral 1088 Turkey Neck Road 21561 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Parts Manager <u>Auto Parts Store</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 01a Lilly Florence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 390 Fox Brier Dr., Ozark AL 36360 <u>David Biser/ Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrett Co.
Mem. Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/09 Oakland, Maryland 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee 1 Matt 203 S. Second St., Oakland, MD 21550 23a. Part 1. Enter the disease, or combining that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been shown that the certificate be executed. Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 20 1 ☐ Yes 2 ☐ No 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | √0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of **E**rtifie 29c. License number 29d. Date signed (Month, Day, Year) D23979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVAL Robert Goralski 311 N. Fourth St., Oakland, MD 21550 31. Date filed (Month, Day, Year) State 32. Registrar's Signature NOV 20 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death

1 - For State Registrar

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	Certifica	ate of Death	Reg. No. 200	9 38364				
hysician	Decedent's Name (First, Middle, Last) WILLIAM JOSEPH BARBER		4.1	Date of Death Month Day Yea					
/Medical xaminer	4a. Facility Name (If not institution, give street and number) Civista Medical Center		City, Town, or Location of Death	4c. County of De	ath les				
neral ector	218-24-6888 ¹ \mathbb{\text{\tint{\text{\tin}\exiting{\text{\texi}\text{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\ti}\text{\text{\texi}\text{\text{\text{\text{\text{\text{	Monti	ths Days Hours Min.	(Month, Dav. Year) (irthplace (State or Foreign Country) RYLAND				
W III	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits					
or 28a-f st be notified Director	MARYLAND CHARLES	WALDORF			Yes 2□No				
ust be n ral Dire	2529 RYCE DRIVE	10f.	Zip Code 20601	10g. Citizen of What (
rat", or items 23a or 28a-f show Examiner must be notified at 1 by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ev Aumed Forces? 1 L Yes 2 No If Yes, Give Year or Dates:	1951- If Yes, s	ecedent of Hispanic Origin? (Specify specify Cuban, Mexican, Puerto Ricans Specify: S 2	/ Yes or No- an, etc.) 14. Race - Ar Black, Wr Specify: B					
s marked other than 'natural', or aumatic event, the Medical Evanti To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 YEAR	life. DO NO	work done during most of working T use retired)	16b. Kind of Busines	·				
event, the Medievent of the Comple	17. Father's Name (First, Middle, Last)	MASON	(LEADER)	FEDERAL G	OVERNMENT				
atic even	TOGETHE DANNER		,	LETON BARBER					
aumat aumat	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Addr	ress (Street and Number or Rural R	oute Number, City or Town, State	, Zip Code)				
em 27 ther tr	MARY E. BROWN / DAUGHTER 20a. Method of Disposition		E DRIVE, WALDORF	·					
Important: It item 27 is marke any injury or other traumatic once.	1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (facemetery, crematory) GATE OF HEAV	EN CEM. NOV. 14	,2009 SILVER SP					
any in	LYDIA C. THORNTON JOHNSON	M00583 7HOR 3439	NTON FUNERAL HOM LIVINGSTON ROAD	E, P.A. , INDIAN HEAD, :	MARYLAND 2064				
ician dical	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)	Porelino		sspiratory arrest,	Approximate Interval Between Onset and Death				
niner		consequence of): m + B bungaguence of):	Bacterenia						
ial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events c	that initiated events							
e as the buris	d	11 1	elynin						
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the second secon	☐ Fetal death 3 ☐ Ectopi	oic pregnancy (specify)	23d. Date of o	delivery Day Ye ar				
d by Ph	Part II. Other significant conditions contributing to death but	not resulting in the underlyin	· .	23e. Did tobacco use contribute	*-				
Completed	0			autopsy prior to performed2 death	autopsy findings available o completion of cause of				
ector, I	25. Was case referred to medical examiner?		26. Place of Death (C		200				
uneral dir	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, (Month, Day, 1		28c. Injury at Work?	5 ☐ Residence 6 ☐ Other (Sp. Describe how injury occurred	pecify)				
led in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	/ - At home, farm, street, fact (Specify)	1 ☐ Yes 2 ☐ No tory, office 28f.	Location (Street and Number or City or Town, State)	Rural Route Number,				
pletely filled	29a. Certifier (Check only one) Certifying Physician: To the best of earth one) Certifying Physician: To the best of earth one)	my knowledge, death occurr xamination and/or investigat d.	red at the time, date and place, and tion, in my opinion, death occurred a	due to the cause(s) and manner at the time, date and place, and d	as stated. ue to the cause(s)				
comp	29b. Signature and title of certifier		tion, in my opinion, death occurred a 29c. License number DY6979 Emboad Scute	29d. Date signed (Mo	nth, Day, Year)				
481	30. Name, and address of pure who completed cause of dea	th (Item 23a) (Type, Print)	ionload Sute	203A. Wal	try no 2061				
State egistrar	31. Date filed (Month, Day, Year) 32. Registrar' NOV 1 2009	s Signature	2						

09-09078 Jason Beavers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	F	Registrar	e of Death Reg. No. 200	9 3831
Physicia al Examir	_	1. Decedent's Name (First, Middle,Last) Jason Edward Beavers	Month Day Year November 22, 2009	Time of Death 0340 hrs
		4a. Facility Name (if not institution, give street and number) Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederick 4c. County of Death Calvert	
Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last birtho	Manufacture Name Name Foreign	ace (State or Vland
nd show any ice.	Ī	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Calvert Prince	2000 ION	Od. Inside City Limits Yes 2 X
death with the Maryland or items 23a or 28a-f show must be notified at once.	Dire	10e. Street and Number 4451 Shannon Way	10f. Zip Code 10g. Citizen of What Country 20678 United State	
	by Funeral	1 Never Married 2 XMarried Armed Forces? 1 Yes 2 X No 1 Widowed 4 Divorced of Pales:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify: 14. Race - American White, etc. Specify:	
uld be filed within 72 hours after Mental Hygiene. marked other than "natural", re event, the Medical Examiner	Completed I	Figure 14ry/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of work done uring most of working life. DO NOT use retired) tal equipment construction	ŕ
thould be filed within and Mental Hygiene. The marked other that is marked other that event, the Med	Be	17. Father's Name (First, Middle, Last) James Thomas Beavers 19a. Informant's Name/Relationship (Type, Print) 19b.	18. Mother's Name (First, Middle, Maiden Surname) Joanne Elizabeth Jones Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z	ip Code)
ages I and 2 shoulent of Health and M nt: If item 27 is m	욘	Jessica L. Beavers - spouse 44	51 Shannon Way Port Republic, MD 20676 Disposition (Name of cemetery, L. Date 20c. Location - City or To	own, State
permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Chesar 21. Signature of Euneral Service Licensee	y or other place) 11/27/2009 Peake Highlands Mem. Gardens 22. Name and Address of Facility Rausch Funeral Home P.	ic Marylar
ysician Medical caminer transit	Examiner	failure. List only one cause on each line.	4405 Broomes Is Rd. Port Republic Menter the mode of dying, such as cardiac or respiratory arrest, shock, or heart, and exycodone intexication	D 20676 proximate terva Between Onset and Death
e death certificate be execut the attending physician and ted for use as the burial - tra	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	permE, g898 12/10/09 TT Fetal death 3 Ectopic pregnancy Month Da Other (Specify)	
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ttending Physician: The law death. tor: After this certificate has y the funeral director, page 2 s	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 V ER/Ou 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Accident Investigation 2 Fd 11/22/09 Fd	tpatient 3 DOA Other, Nursing Home 5 Residence 6 Other: ime of Injury 28c. Injury at Work? 28d. Describe how injury occurred unk	David Niverbay Cit
Hospital or Attending Physician: The la 24 hours after death. Funeral Director: After this certificate ha stell filled in by the funeral director, page 2	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Ou 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) House 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal	tpatient 3 DOA Other Nursing Home 5 Residence 6 Other: ime of Injury 28c. Injury at Work? 28d. Describe how injury occurred unk 2:59 am 28f. Location (Street and Number of Rure or Town, State) 445 I Shan Port Republic, MD th occurred at the time, date and place, and due to the cause(s) and manner as stated.	d.
ling Physic After this funeral dir	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Ou 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) House 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal	tpatient 3 DOA Other, Nursing Home 5 Residence 6 Other: ime of Injury 28c. Injury at Work? 28d. Describe how injury occurred unk 2:59 am 28f. Location (Street and Number of Rure or Town, State) 4451 Shan Fort Republic, MD	d. cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item state #26, per phys, 11/12/09, BA 38366 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <u>Evelyn C,</u> Boris 11/05/2009 1:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Year) Months Days Hours Min. 1 □ M 2 👿 F Director 97 08/20/1912 PA 171**-**01-5875 Usual Residence of Decedent the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Examinational Examination and 10h County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No PA Delaware Ridley Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 55 Hetzel Road 19078 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify ģ Specify: In 1 ie 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerk dry cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Condy Bott Anna Seppi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Emily Drive, Salisbury, MD 21804 (niece) <u>Joanne Kasper</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemeterv 11/10/2009 |Drums_PA 21. Signa are of Funeral Service 22. Name and Address of Facility The Burbage Funeral Home Berlin, MD 21811 108 William St. 23a. Part / Enter the diseas shock, or heart failure. Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardi, cor respiratory arrest, List only one cause on each line Approximate Interval Between Onset and Death **Physician** 6 disease or condition resulting in death) Money /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-trar as a consequence of): Due to (or Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 □Yes 1 ☐ Yes 2 No 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DCA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manne eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of co 29c. License number Fe 402 Berlen 11d 218/1 npleted cause of death (Item 23a) (Type, Print) BA 15 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar 05 0 NOV 12

DHMH 17 Rev 1/2001

Box 68760, P.O. Division of Vital Records,

Examiner that the death certificate be executed burial-transi and attending physician for use as the buria signed by the a completely filled in by the funeral director, After this Hospital or Attending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

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of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm "Medical Examinar must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hi Important: If item ZZ is marked oth any linjuy or other traumatic event once.

Physician /Medical

2 should be filed within 72 hours after death with is and Mental Hygiene.
is marked other than "natural", or items 23a or ;

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Tes 2 No 27. Manger of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

29b. Signature and the of certified

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

TROST ROCKVILLE, MDZC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38368 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2009 Month MOZELLA 1 12.05 PM RENNETT NOV. 05 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince Patrixent River Health annel George's And Reheb 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 1 M 2 X 046-36-7279 64 fla. 08/19/45 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Bowie Prince George Md 1XIYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20720 13306 Big Cedar Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Private College (1-4or 5+) Administrate ASst 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Doris Black Authur T. Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13306 Big Cedar Lane Bowie Maryland 20720 Daughter Mary Bailey 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Riverdale Crematory 11/16/09Riverdale, Md 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Sneadd Morfettary Service 21. Signature/of Funeral Service Licensee PA 0777 1409 Fairlake Pl Ste B'Mitchellville, Md 23a. Part 1. Enter the difease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Salerusis Years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any liury or other traumatic event; If Medical Examinar must be redified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit

Division of Vital Records, P.O. Box 68760,

Cause (Disease or injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day Year
	, , , , , , , , , , , , , , , , , , , ,	obacco use contribute to the cause of death?
Diabetra mel	autop	an 24b. Were autopsy findings available sprior to completion of cause of death?
25. Was case referred to medical	26. Place of Death (Check only o	ne)
examiner? 1 ☐ Yes 2 🔁 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resid	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1	now injury occurred
3 Suicide 6 Could not determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Scity or Toy	Street and Number or Rural Route Number, vn, State)
29a. Certifier 1 ☑ Certifying F (Check only one) 2 ☐ Medical Exa	Hysiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the uniner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	cause(s) and manner as stated. date and place, and due to the cause(s)

29c. License number

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Bourse

D 53411

Shesadri

29d. Date signed (Month, Day, Year)

NOV

20715

OSIF

2009

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

14300

31. Date filed (Month)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gallant Fux

NOV 1 ()

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32. Registrar's Signature

Proces

		1 - State Registrar		Cei	rtificate of	Death	Re 2. Date of Death	g. No2 (009	383	
Physic /Medi		1. Decedent's Name (First, Middle, La Fred W. Breslin	st)				November	Day	Year 2009	3. Time of 1:00	A M
Exami		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death)	4c. Cou	nty of Death		
		St. Mary's Hosp				eonardtow			St. Ma		
Funeral Director		177-20-4406	Sex 7. Age (In yrs. Ii ■ 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 12			place (State ontry) nsy1va	
3		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or La	ocation				T	10d. Inside Ci	ity Limit
fisho	ō	,	Mary's		Leonar	dtown				1 ∑ Yes	2 🗆 N
28a	rec	10e. Street and Number	101) 0		10f. Zip Code	d LOWII	10	g. Citizen	of What Cou	ntry?	
23a o st ta	Funeral Director	22680 Cedar Lan	e Court Apt.13	317		20650		Ţ	JSA		
sme.	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H	Hispanic Origin? (S an. Mexican, Puert	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White,		
portion: Tagor Planta and Martal Hygiene. Indicate the state of the st		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 ☐ No If Yes, Give Year or Dates:		1 □Yes 2 🙀 No	Specify:		1	cify: Whi		
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ked o	To Be	William Joseph				Viole	t Christi	ana F	Rupp		
nd M mari	Ĕ	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street		ral Route Number,			ip Code)	
alth a 27 Is er trai		Anne Marie Bres	lin / Wife	22680	O Cedar L	ane Cour	t Apt.131	l7 Led	nardt	own,MD	206
item other		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other pla	ce) Nove		20c. Location	on - City or T	own, State	
ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Speci</i>	Themoval from State		eace Cemete	: MOACH	nber 5,	Helen,	Maryla	nd	
Departr Imports any inju		21. Signature of Funeral Service Lice	Trademen)	22	2. Name and Addre		Funeral Hondtown, MD 2	ne, P.A	١.		
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attending physic	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d.	Date of deli	very	
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sert	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Impatient 2	EB/Outnatie	nt 3 DOA Oth	ner:	ath <i>(Check only one</i> Iome 5 ☐ Reside		Other (Spec	vifu)	
<u> </u>	II—II	27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Inju	ry at	28d. Describe ho			шу)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		artment of F ertificate of	Health and M <i>Death</i>		eg. No 2009	38370
	Physici	an	1. Decedent's Name (First, Middle, Las Mary Hele	<i>'</i>				2. Date of Death Month	Day Year	3. Time of Death 4:00 PM
- de	/Medi Examir		4a. Facility Name (If not institution, give			4b. City. Town, o	or Location of Death	November	4c. County of Death	4.00 110
1	Exami	e	Fairfield Nursing				wnsville		Anne Arun	de1
	Funeral Director		5. Social Security Number 6. Se 266-86-3579	ex 7. Age □ M 2 🖾 F	(In yrs, last birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, September		place (State or Foreign ntry) aryland
	pur 🔉		Usual Residence of Decedent 10a, State 10b. County		ocation			1.	0d. Inside City Limits	
	e Maryla la-f sho	ctor	Maryland Anne Arun	del	10c. City, Town or Ł		cownsville			1 □ Yes 2 No
	th with the Marylan 23a or 28a-f show	Funeral Director	10e. Street and Number 1454 Fairfield Loop	Road		10f. Zip Code	21032	10	og. Citizen of What Coul USA	ntry?
9800	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, it a Macical Examinations to profiled at	by	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ∐Yes 2 X N If Yes, Give Ye ar or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 □Yes 2 🕅 No	dispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whit	etc.
Maryland 21215-0036	2 30	Completed	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-	(Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of working	19	l6b. Kind of Business/In	dustry
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pu	be file tal Hy d oth event	Be (17. Father's Name (First, Middle, Last)	_			18. Mother's Name		·	
yla	ould by Men	P	William Thomas	Bennett			Margaret	Eleanor		
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (7)					,	City or Town, State, Zip	Code)
	1 and Healt tem 2		Edith Bennett E 20a. Method of Disposition	lliot / Niec	·	Denbigh Blv osition (Name of ematory or other place	rd #208, Newp		VA 23601 20c. Location - City or To	own. State
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Bal	permi Depar Impor any ir	. 55	21. Signature of Funeral Service Licens	rdiner Funera] Leonardtown,	Home, P.A. MD 20650					
	23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,									
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.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as to	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
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Records,	w requir s been s should	lete			-			24a. Was an	24b. Were auto	psy findings available
	: The lay cate has page 2 :	Completed						autopsy perform	prior to co	mpletion of cause of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			
of	Phys r this ral dir	٠ <u>.</u> ت	1 ☐ Yes 2 ☑ No	1 Inpatien	t 2 ER/Outpatie	nt 3 DOA	er: 4 Nursing Hom	ne 5 Resider	nce 6 Other (Special	(y)
on	Attending Physician: If death. ector: After this certific by the funeral director, I	ţ	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,		Worl	yat ⟨? Yes 2□No	od. Describe nov	w injury occurred	
Division	7 to 1	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)			8f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital of within 24 hours all To the Funeral D completely filled in	Medical C	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of iner: On the basis of and manner state	examination and/or i	th occurred at the timestigation, in my o	me, date and place, a pinion, death occurre	and due to the ca	use(s) and manner as s te and place, and due to	stated. the cause(s)
	To ti To ti	Ž	29b. Signature and title of certifier	00	10 11 1	29c. Licens		29	d. Date signed (Month,	Day, Year)
			· Mul	en l	Cer MD	MB	59198	/	1/12/09	
			30. Name and address of person who co						, , , , , , , , , , , , , , , , , , , ,	
	Sta	e	Richard S. Rees, M 31. Date filed (Month, Day, Year)	D. 15013 Ro 32. Registrar		Drive , G1	enwood, MD 2	1738		
	Registra		NOV 16		un \$.	park				

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			For State Registrar		State o	f Marylar		artmer				ental Hy	•	0000		271
	· -		Decedent's Name (First,	Middle, Last	t)		00	illica	011	Deam		2. Date of De	Reg. No	2005	3 Tim	e of Death
	Physic			nn Bir	•							Month Novembe	Da	Year 1, 2009		
	/Medi Exami		4a. Facility Name (If not ins			mber)		4b. City	Town, or	r Location		NOVEMBE		. County of De		10 p.₩.
			St. Mary's H	lospita	al			Leon	ardt	own			S	t. Mary	1 S	
	Funeral		5. Social Security Number	6. Se	х] м 2 X] F	7. Age (In yrs.	• • •		r 1 Year		Min.	8. Date of Bir (Month, Da	rth	O Ri		te or Foreign
	Director		215-62-9165 Usual Residence of Deced		JW ZAJF	61	Yrs.		,-			12/12/1	1947		yland	
	land ow		10a. State 10b. C			10c. Ci	ity, Town or Lo	cation							10d. Insid	e City Limits
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	h the	Director	10e. Street and Number	_rial y	5	DC.	Inigo	10f. Zi	Code				10g. Ci	tizen of What C	ountry?	
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	r dea	Funeral	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Dece	dent of Hi	ispanic O	rigin? (Spe	cify Yes or No Rican, etc.)		14. Race - Am Black, Whi	erican Indiar	9
36	s afte	by F	1 Never Married 2		1 ∐Yes If Yes, Gi	ve		1 □ Yes		Specify		noun, orony		Specify:	te, etc.	
ç	hour tural	ed b	3 Widowed 4 Div		Year or D	ates:	160 Dagg	dont's Hau	al Ossun	otion			465 1	В	lack	
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5	e file al Hy l'othe vent,	Be	17. Father's Name (First, N	liddle, Last)						18. Moth	er's Name	(First, Middle				
<u>a</u>	arked	၉	Arthur R. Bi	rdine						Mary	Loui	se Bal	1			
Maryland 21215-0036	2 sho		19a. Informant's Name/Re	ationship (T)	rpe. Print)		19b. Mailir	ng Address	(Street a	and Numb	er or Rural	Route Numb	er, City	or Town, State,	Zip Code)	
<u>a</u>	and lealth im 27		William Barn	es			20852	Her	nanvi	<u>i11e</u>			igtoi	n Park,	MD 2	0653
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Evanther must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Crem	ation 3 ☐ F	Removal from	State	Place of Dispo cemetery, cren					ate		ocation - City o		
	it. Pa rtmer rtant njury		4 ☐ Donation 5 ☐ Ot	her (Specify)		Mt.	Zion	Chur	ch Ce	em 1	1/17/	2009	St.	Inigoe	s, Mar	yland
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	Discolation		shock, or heart failure Immediate Cause (Final	List only or	ne cause on e	ach line.		er trie mot	e or dylli	y, such as	cardiac oi	respiratory a	irest,		Approxit Interval Onset a	Between nd Death
	Physician /Medical		disease or condition resulting in death)		a	or as a conseq		516	7-14	120					1.0	VIEN
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	cate be executed others and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events		, JEn.	2 Stag	e Re	ine/	6	silv	re				Year	5
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∑ Y of o	Physician: rthis certifica ral director, p		examiner? 1 ☐ Yes 2 X No	H	lospital: 1 ☐ i	npatient 2	ER/Outpatien	t 3 🗆 DC	Othe					6 ☐ Other (Spe	ecify)	
	Ing P	Certification: To	27. Manner of Death 1 X Natural 5 □ P	ending	28a. Date of (Mont.	of Injury h, Day, Year)	28b. Time of Injury	2	8c. Injury Work			3d. Describe I				
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Division	or All	ij		etermined	28e. Place buildir	of Injury - At hong, etc. (Specif	ome, farm, stre y)	et, factory	, office		28	If. Location (8 City or Tov	Street ar vn, State	nd Number or R	ural Route N	umber,
a _	pital ours a eral l		29a. Certifier 1X Ce	rtifying Phys	sician: To the	heet of my kno	wledge death	occurred	at the tim	o data a	ad place o	ad due to the		and manner a		
\equiv	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	(Check only 2 Me	dical Examin	ner: On the ba	asis of examina	tion and/or inv	estigation	, in my op	pinion, dea	ath occurre	d at the time,	date an	d place, and du	is stated. e to the caus	e(s)
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	3 ma	İ	30. Name and address of pe	erson who co	mpleted cause	e of death (Item	1 23a) (Type, F	Print)		762	73		170	vembe	7 1 4	2009
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ a0009 0540 AM Karen M. Berg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, August 22 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Davs Hours Country)
Pennsylvania Director 168-44-1732 56 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland St. Mary's Hollywood 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44633 Joy Chapel Road 20636 USA iral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 M Married X Yes 2 No Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: White "natural", Specify 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be i John Trangradi Mary T. Afflerbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Moore / Daughter 2840 Neptune Court Philadelphia, PA 19154 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 and Department of I mportant: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State November 19 2009 Bensalem, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Allied Crematory Signature of Funeral Service Licens 22. Name and Address of Facility Mattingley-Gardiner Funeral P.O. Box 270 Leonardtown, Maryland 20650 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician. UNG mass disease or condition resulting in death) Medical onsequence of): Due to (or as Examiner Right Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed as the burial-transi abilrect re attending physician and that initiated events resulting in death) Last Due to (or as a consequence of Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery P.O. Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year 4 ☐ Pregnant a 9 ☐ Unknown 1 ☐ Yes 2,≥ 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Vital Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this of 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: T. the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on and title of centifie

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Registrar

State

81. Date filed (Month, Day, Year) NOV 20

MEHROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

May 1) Hospita ALCHLAGHI Registrar's Signatur

DO0 6047

29d. Date signed (Month, Day, Year)

2009

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #10c, #1- State Registrar 10e, #10f, TCHD, 11/09/2009, Certificate of Death TLS 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** DOUGLAS P BALDWIN NOVEMBER 5 2009 11:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F Birthplace (State or Foreign
Country) Funeral Months Hours Days 89 Yrs. **Director** 144-16-1173 01/31/1920 **NEW JERSEY** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, It is Medical Examinating the indifficit at 1 Yes 2 No Director MARYLAND TALBOT ST. MICHAELS MCDANIEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23266 MALLARD POINT ROAD DRIVE **21663** 21647 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2**x** ☐ No Specify: Specify.WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE CERAMIC ENGINEERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLARENCE EDWARD BALDWIN HAZEL PIER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES JOAN BALDWIN/WIFE 23266 MALLARD PT DRIVE, MCDANIEL, MD, 21647 20a. Method of Disposition

1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD CHESAPEAKE CREMATION 11/07/2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANCER Immediate Cause (Final BILLARY TRACT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Disc to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Attending Physician: The law requires that the death certificate be executed physician and strans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) 9 Unknown á signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performed? 1 ☐ Yes 2 💆 No certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Vinit Tohum 20057908 11/5/09 TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+VA 800 S TALBOT ST SI MICATECS MD PATTERSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** November 8, <u>4:4</u>5 p.[™] Gary 2009 Robert Barrett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Hours Min. 218-42-2906 65 09/15/1944 Nebraska Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2 No Director MDAnne Arundel Fairhaven 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 Herring Avenue 20779 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give A Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) copper cable splicer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lincoln Barrett 2 Marian Ruth King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillie Talbott Barrett, wife 502 Herring Avenue, Fairhaven, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/11/09 | Alexandria, VA of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiogenic 1 HOUR or myocardial infaction 3 Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co quence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner? Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

Funeral

Director

items 23a or 28a-f showner must be notified at

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'natural",

7 is marked other than "nature traumatic event, the Medical

Department of Health a Important: If item 27 Is any Injury or other traconce.

Physician

/Medical Examiner

physician and the burial-transit

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed ed by the a has certificate ha irector, page 2 Hospital within 24 hours To the Funeral

State Registrar

in by 1

completely

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of deat

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Tedical Parki

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day BETTY BARTENSTEIN NOVEMBER 5,2009 10:10A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL

5. Social Security Number 6. Sex HOSPITAL FREDERICK
If Under 1 Year | If Under 24 Hrs. | FREDERICK 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 16, 9. Birthplace (State or Foreign Country)
Ohio **Funeral** Months Days 1 ☐ M 2 🐼 F Hours Min. 579-28-5849 81 **Director** Usual Residence of Decedent 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland | Frederick Frederick with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5955 Quinn Orchard Road, Apt. 116 21704 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any highry or other traumatic event, the Medical Examinations once. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Wilford P. McConoughey Elizabeth Ridgeway 21704 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Bartenstein / Husband 5955 Quinn Orchard Rd., Apt. 116, Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthayen
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Nov. Io, 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland 21. Signature | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fun | Fu Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or shock, or heart failure. List opplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumon o disease or condition resulting in death) l Werk /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are thing in depth), lost Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant uyes 2∑No 9 □ Unknown 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) detached signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 X No 3 Probably 4 Unknown 1 ☐ Yes Completed Hyper tension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Yes 2 spital or Attending Physician: Thours after death.
Ineral Director; After this certificate y filled in by the funeral director, pa 1 □ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1☐ Yes 2X No Hospital: Other: 4 \(\sum \) Nursing Home 1**X** Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or within 24 hours at To the Funeral D

State Registrar

(Check only one)

title of certifier

29b. Signature

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

and manner stated.

is of person who completed cause of death (Item 23a) (Type, Print)

nomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Kenneth Eugene Burdette November 5 8:40 2009 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederica

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Feb. 2, Frederick Frederick 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 78 Director 214-32-9129 Usual Residence of Decedent with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XX No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6946 Sundays Lane 21702 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 Ño Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Laboratory Technician Biotech Research 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fillent of Health and Mental Htt: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Nichols Burdette Alice Marie Nicholson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Burdette / Wife 6946 Sundays Lane, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Nov. 9 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or or co. Resthaven Crematory 4 Donation 5 Dother (Specify) 2009 Frederick, Maryland 21. Signature of Funeral Service Licensee Resthavenes Tufferal Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the unlease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** Schenesis Conormy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYVENTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed and -tran physician a s the burial-Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 □Yes 2 XNo 2 No 1 🗆 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭X No Certification: To this 1 Inpatient 2 X ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No the 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) [Wt 11-09-2009 30 Herre and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICE, Toll House ALE A. KAZMI, MD 814 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001 1 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5, November 2009 5:00 P ^M <u>John Brennan</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Golden Living 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **™** M 2□ F Months Days Hours Pennsylvania 76 1932 Dec.13, 213-30-2976 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2□No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country United States 21702 2508 Coach House Way, Apt. #3A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 □Yes 2 🕅 No Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pest Control Manager 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Malden Surname) Sara Lawrence William Brennan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2508 Coach House Way, Apt #3A, Frederick, MD 21702 Doris Brennan / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/7/2009 Frederick, Maryland Stauffer Crematory Stauffer Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ATHEROSCLENOSIS DISEASE Anteny ononny disease or condition resulting in death) Due to (or as a consequence of): EMENTIA Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

signed by the attending physician and d be detached for use as the burial-transit cate has been si page 2 should b this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

The law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be ည

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinating to active traumatic event, the Medical Examinating to active traumatic.

Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ð Completed Be Certification: To

Medical

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide 29a. Certifier

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number DO0 4795

29d. Date signed (Month, Day, Year) 11-06-2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Ave thenerica, MD 2170 KAZMI, MO 814 TE 1101

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ OSIFOH 30 M . Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 9. Birthplace (State or Foreign Country)
Clear Spring, MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 05/06/1928 Director 218-24-7752 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 🗆 Yes XX No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 463 Severnside Drive 21146 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seponday (0-12) College (1-4 or 5+) Accountant GA₀ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Newcomer E11a Louise Boward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 463 Severnside Drive Severna Park, MD 21146 Ruth Boyd Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 11/09/09 Crownsville,MD Signature of Sungral Service Licenses 22. Name and Address of Facility 12 Ridgely Ave Annapolis MD 21401 Gate Hardesty Funeral Home P.A. 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ SEPSIS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that introduces or impury Examine Due to (or as a consequence of) and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) anding physician a use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death
9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No **Division of Vital** Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 2 Medical Examiner: On the Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🚁 is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practic the best of my knowledge. at the time, date and place, and dee to the a ature and title of contifier ame and address of person the completed cause of death (Item 23a) (Type, Print)

(ICH) ARC J. Car ENTA MI) 445 DEFENSE HANNAM ANNAMU) MAZ 14VI

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

09-08669

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ristian Bosies		State of Maryland / Department of - For State Certificate of	Health and Mental Hy Death	Reg. No. 20	09 3837
Physicia edical Examin	ın/	1. Decedent's Name (First, Middle,Last) Christian Michael Bosies		Date of Death Month Day Year November 7, 2009	3. Time of Death 2009 hrs
		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center	4b. City, Town, or Location of Death Salisbury	Wicomico	
Funeral Director		5. Social Security Number 221–56–9240 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Age (In yrs. l	If Under 1 Year If Under 24Hrs Months Days Hours Min	Fore	irthplace (State or eign Metryland
w any	F	Usual Residence of Decedent 10a. State	ion		10d. Inside City Limits 1 X Yes 2 No
e Maryland or 28a-f show	Director	Delaware Sussex Delmar 10e. Street and Number 202 N. 2nd St., Apt. 2	10f. Zip Code 19940	10g. Citizen of What Co	ountry?
and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral D	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	as Decedent of Hispanic Origin? (Si es, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	
hours after of natural", or Examiner m	2	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Deceder during metals and the second	Yes 2 X No specify: nt's Usual Occupation (Give kind of nost of working life, DO NOT use ret	work done 16b. Kind of Busines	hite s/Industry
215-0036 be filed within 72 ntal Hygiene rked other than " ent, the Medical I	Completed	12		e (First, Middle, Maiden Surname)	ion
ID 21215-0036: should be filed within 77 and Menial Hygiene. 77 is marked other than natic event, the Medical	Be	17. Father's Name (First, Middle, Last) Harry Hilton Bosies 19a. Informant's Name/Relationship (Type, Print) Bonnie J. Bosies/spouse 20	Mildre g Address (Street and Number or 2 N 2nd St An	d Beckwith Rural Route Number, City or Town, State 2, Delmar, DE	ate, Zip Code)
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Dispocrematory or o	sition (Name of cemetery, ther place)	Date 20c. Location - City	or Town, State
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: Parsons (Name and Address of Facility Holloway Funeral	/13/09 Salisbur L Home Professiona d., Salisbury, MD	al Association
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease)	the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
caminer	_	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
bd Isit	Examiner	(Disease or injury that initiated events resulting in death) Last			
O, be executed sician and burial - transit	edical	d. UNPENDED AMENDED		23d. Date of deliv	Verv
Box 68760, he death certificate be enough the attending physician hed for use as the burial	sician/M	past 12 months?	Tetal death 3 Ectopic pregrother (Specify)		Day Year
ires that the d signed by the be detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 F	
ords law requi has been 2 should	Completed			24a. Was an autopsy performed? 1 V Yes 2 No 1 V	
ital Recision: The scerificate	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ▼ ER/Outpatie	26.Place of Death (Checont 3 DOA Other Nurs		other:
ion of Vital Rectending Physician: The leath. Ior: After this certificate the funeral director, page	tion: To	27. Manner of Death 1 ✓ Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Death (Month, Day, Year)		28d. Describe how injury occurred	
Division Attents or Attents after deserted in Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, str	reet, factory, office building, etc.	28f. Location (Street and Number o or Town, State)	r Rural Route Number, City
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filted in	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investign and manner stated.	pation, in my opinion, death occurred	d at the time, date and place, and due t	to the cause(s)
	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.	November 8,	(Month, Day, Year) 2009
12mp		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MD 21201		
S Regis	tate		arke		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{.0}20 2009 **Physician** NOVEMBER BRENDA LEE BOBO 5:36a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Union Hospital Elkton Cecil If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 🗶 F 205-52-5689 49 Director Pennsylvania Sept 8 1960 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Yes 2 □ No Director Chesapeake City MD Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 100 Grayson Ave. Apt. 206 21915 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 Mar 1 f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: δ Specify: White 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, Ir a Manual Injury or other traumatic event, Ir a Manual Injury or other traumatic event, Ir a Manual Injury or other traumatic event, Ir a Manual Injury or other traumatic event, Ir a Manual Injury or other traumatic event, Ir a Manual Injury or other traumatic event, Ir a Manual Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Someone else's home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Bobo, Sr. Helen Huff 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnnie L. McRae, Jr. 110 Quail Court Elkton, MD. 21921 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Kent Cremation 11/26/09 Smyrna, DE. 21. Signature of Fundal Service License 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) **Physician** aute my ound infection /Medical Due to (or as a consequence of): Examiner Premica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed COPD and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria nellets Diates Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1∐Yes 2⊠No the 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2....No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a Hospital cal 29a. Certifier 1' 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3h

DHMH 17 Rev 1/2001

State

Registrar

within 2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

In Cill Now MD

MEC 0 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32

egistrar's Signature

223 West

29d. Date signed (Month, Day, Year)

maist, EllChon Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State o	f Marylan		artmer			and M		giene Reg. No. 2	2000	3 3 8	381
			Decedent's Name (First, Middle, Last	")							2. Date of De Month		Year	3. Time of	Death
	Physicia /Medic			Daisy	Mae By	rd					Novembe	er 22	2009	1010	A^{M}
1	Examin	er	4a. Facility Name (If not institution, give	street and nui	mber)				Location of	of Death			ounty of Dear	h	
ng K	Francis		Union Hospital 5. Social Security Number 6. Se	x	7. Age (In yrs.	last birthdav)		kton	If Under	24 Hrs.	8. Date of Bir		Cecil	hplace (State o	r Foreian
	Funeral Director			□M 2 X)F	78	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da AUG 24	y, Year) 1931	Co	elaware	- 0
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cation							10d. Inside Ci	tv Limits
	Maryia f sho	ro				lkton	odilon							1 🗌 Yes	
	r 28a	Directo	Maryland Cecil		E.	IKLOII	10f. Zi	p Code				10g. Citize	en of What Co	untry?	
	th with	ralD	45 Chestnut Drive	2			2	21921				U	nited	States	
	ltems	Funeral	11. Marital Status	Armed Fo	edent Ever in U.	.S. 13.	Was Dece If Yes, spe	dent of Hi ecify Cuba	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 14	 Race - Ame Black, White 		
20	Irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ∐Yes If Yes, Gi Year or D	ve		1 🗆 Yes	2 💢 No	Specify:			s	Specify: V	hite	
2-003p	72 hou		15. Decedent's Edu (Specify only highest grad	ucation		16a. Dece	dent's Usu	ial Occupa	ation luring mos	t of worki	na	16b. Kind	of Business		
7	ithin 7	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT L	ise retired)	t or works	rig	т	II O		
7 0	filed w Hygie ther t		12 17. Father's Name (First, Middle, Last)			НО	memal	cer	18. Mothe	er's Name	(First, Middle			wn Home	
yland	lid be lental ked o lic eve	To Be	William Franklin	Wilmer					Vic	ola M	lae Evai	ns			
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examinar must be rediffed at once.		19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	ng Addres	s (Street a			al Route Numb		Town, State,	Zip Code)	
∑ m`	and and lealth m 27 her tr		Rodney L. Wilmer/	'Son					treet		kton, l		1921	Taura Chala	
פַ	ages 1 nt of h t: If ite r or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		State Gi	Place of Dispo Cemetery, cres Lpin Ma	natory or an anor	other plac	e) N	lovem			ation - City or		
Бант	nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License		Me	morial	Park	-	i Z	25, 2	.009	E.	lkton,	MD	
ñ	imp per jup any onc		Dones	S. A	ن داد د	H:	icks 03 W.	Home	for	Fune	rals, E	kton	MD 1	21921	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that one cause on e	aused the deat								,	Approximat Interval Bet	ween
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i	/Medical Examiner		resulting in death)	Due to	(f as a conseq	luence of):									
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Ď,	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to	(or as a conseq	(uence of):									
09/99	certificate nding physi	Physician/Medical		d											
X OX	leath certifica attending ph for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		75-4					23	3d. Date of de	livery	
	e death he atter ed for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2□Feta nant at time of a nown		☐ Ectopic ☐ Other (s		y 				Month	Day	Year
ŗ.	hat the d by t letach	Phy	9 Unknown Part II. Other significant conditions of			sulting in the u	nderlying	cause nive	an in Part I		23e Did	ohacco us	e contribute t	o the cause of	death?
ecords,	w requires that the dispersion is been signed by the should be detached	d by	Tay in Otto Significant conditions of	orking to a	oddir but flot for	anning in the d	naony ng	oddoo g.v.	J			Yes 2□		robably 4 🗹	
င္ပ	w req	Completed									24a. Was	an	24b. Were a	utopsy findings	available
r	The la	omo									auto perfo 1 ☐ Yes	rmed?	prior to death? 1 □Ye	completion of o	ause of
VItal	sician: The law certificate has b irector, page 2 sl	Be C	25. Was case referred to medical examiner?							e of Deat	h (Check only				
<u>_</u>	Physician: The this certificate har director, page	1	1 ☐ Yes 2 ☐ No 27, Manper of Death	Hospital: 1 2 28a. Date		ER/Outpatie			4 🗆 N		ome 5 Res			ecify)	
0	ding th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Mor	nth, Day, Year)	Injury	M	28c. Injur Work 1 🔲	yai (? Yes 2□		28d. Describe	now injury	occurred		
DIVISION	Atter	Certification: To	3 Suicide 6 Could not be determined	Zee. Flace	e of Injury - At h	ome, farm, sti	reet, factor	ry, office			28f. Location (Street and	Number or F	ural Route Nur	nber,
בֿ	Ital or Irs afte ral Dir Iled in	Cert													
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i	ledical	29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medical Exam	iner: On the b											s)
	o the vithin 2 omple	Mec	29b. Signature and title of certifier	andman	iller stated.		29	9c. Licens	e number			29d. Date	signed (Mon	th, Day, Year)	
	->-0		> Sachde	1-5-1	1D.			0000	2332	2		1	1.23.8	2009.	
			30. Name and address of person who	completed cau	se of death (Ite	m 23a) (Type,	Print)	_	017	NA.	036	. /			
	Sta	ate	S.S SACHDEV / 31. Date filed (Month, Day, Year)	32/1	Registrar's Sign	ature ature	07,		reles	7/1	0219.	2/			
	Registr		31. Date filed (Month, Day, Year) DEC 0 2 200	19 de	we ,	9. Asa	West .	,							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		Cert	ificate of L	Death	R	leg. No. 201	19	38382		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					Date of Deat Month		Year	3. Time of Death		
	Medic		ROBERT	DELAUTER		YER		NOVEMBE			8:14P M		
	Examin	er	4a. Facility Name (if not institution, give stre				Location of Death		4c. County of Death FREDERICK				
	Funcyal		FREDERICK MEMOR 5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	FREDERI If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	place (State or Foreign		
	Funeral Director		220-18-0872 X [□]	M 2 □ F 83	Yrs.	Months Days	Hours Min.	Jan. 2ª,	^y ¶926	Marry	71and		
	d tow	_	Usual Residence of Decedent 10a, State 10b. County	10c. City.	Town or Loca	ation				1	0d. Inside City Limits		
	arylan a-f sh fied a)cto	Maryland Frederick		ederic						1 ☐ Yes 2 🛣 No		
	he Mis or 28; noti	ä	10e. Street and Number		_	10f. Zip Code			10g. Citizen of W	hat Coun	itry?		
	with t	Funeral Director	5427 Camp Raudy Ro	ad		21702			U.S.A.				
	death items	필	111 Marital Otatao	. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- America			
36	after or vamir	d by	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give 1952-19	953 1	☐ Yes 2 🙀 No			Specify:				
8	hours hatura ical E	Completed	15, Decedent's Educa	ation	16a. Decede	ent's Usual Occup	ation	1	16b. Kind of Bus				
212	e. Pan "r	dwo	(Specify only highest grade of Elementary/Seconday (0-12)	Completed) College (1-4 or 5+)	(Give ki life, DO Tah	ind of work done of NOT use retired) Reseache	during most of work	ing	Governm	nent			
2	d with lygien ther tl	BeC	12		Lab			- /First Stielelle S					
and	be filer ental H ked of ic ever	10 B	17. Father's Name (First, Middle, Last) Lester Walter Bo	yer			18. Mother's Nam Rebecca		DeLaute				
Mary	12 should alth and M 27 is man r traumat		19a. Informant's Name/Relationship (Type, Mr. Robert D. Boyer	I.	19b. Mailing 8213 E	a Address (Street de de de de de de de de de de de de de	and Number or Run Church Ro	al Route Number, Dad, Fre	City or Town, Sta derick,	ate, Zip C	21702		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked or any injury or other traumatic event, the Medical Examiner must be notified at another.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 20b. Pla	ace of Dispos metery, crem Hope	ition (Name of atory or other plac Cemetery	Nov. 30	Date , 2009	20c. Location - 0 Woodsbor	•			
Baltii	permit. F Departm Importa any inju		21. Signature of Funeral Service Lio Insee	M0025	5 10	Nakeeneye 16 East (sando Basfo Church St	ord PA F	uneral H	Home.	701		
			23a. Part 1. Enter the disease, or complica	ations that caused the death.							Approximate		
	ากงรางเลก		shock, or heart failure. List only one of Immediate Cause (Final disease or condition	Probable	100 (200)	laibana	infanc	tion			Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	2-1 Coloci	V()	,,,,,,		\neg			
		Jer	Sequentially list conditions, b.	Due to or as a conseque	ence of:					+			
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.										
	nath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):								
8760	ate be	Medical	d.										
687	sertific Iding p		IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregnand	су				23d. Date	e of deliv	ery		
Box	ie death of the atter shed for u	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Fetal 4 Pregnant at time of de 9 Unknown		Ectopic pregnand Other (specify)	cy		Mon	ith	Day Year		
P.0	es that the dea signed by the a be detached f	by Pt	Part II. Other significant conditions contr	buting to death but not resul	lting in the ur	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contril	bute to th	ne cause of death?		
ds,	requires been sig should b		1					1 🗆)	∕es 2 ☐ No	3 🗌 Prot	bably 4 Unknown		
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death cen within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending the Funeral filed in by the funeral director, page 2 should be detached for use	Completed						24a. Was a autop perfor 1 Yes	sy page de de de	Vere autor rior to co eath?	psy findings available mpletion of cause of 2 No		
tal	cian: ertifica	Be Be	25. Was case referred to medical examiner?	spital:		LONI	lace of Death (Chec		_				
Ę	Physia this c	<u>و</u>	1 Yes 2 No	1 Inpatient 2 🗶 E	R/Outpatient 28b. Time of	t 3 DOA Oth	4 □ Nursing H		ence 6 Other		2		
0 0	ding th.	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	worl	yai <br Yes 2 □ No	260. Describe no	ow injury occurre	u			
ivisio	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Town	treet and Number n, State)	r or Rural	Route Number,		
۵	To the Hospital within 24 hours a To the Funeral C completed filled	Medical (an: To the best of my knowle	dge, death o	ccured at the time	e, date and place, a	nd due to the cau	use(s) and manne	r as state	3d.		
	the Ho lin 24 the Fu	Med	only one) 3 Certifying Nurse	On the basis of examination ractioner: To the best of my	and/or investi knowledge, d	eath occurred at the	ne time, date and pla	ce, and due to the	cause(s) and mar	nner as st	ated.		
	Vitt		29b. Signature and title of certifier			29c. Licens			29d, Date signed				
)		WAL		20-) =		035267		11-2	5-7	2007		
-			30. Name and address of person who com Manuel A. Casiano	, M.D., 400 W	23a) (Type, Pi Test 71	th Stree	t, Freder	ick, MD	21701				
	Sta		31. Date filed (Month, Day, Year) OFC 0 2 2009	32. Registrar's Signatu									
	Reaistr	ar	TIFL II Z. LUUJ	LUNCOUNT /CO	Name and Address of								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38383 State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year JOHANNA ANNA BRENNAN PM NOVEMBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATA If Under 24 Hrs. CHARLES MEDICAL CENTER ATZIVI 8. Date of Birth (Month, Day, Year) 8-27-1914 5. Social Security Number 7. Age (In yrs. last birthday) If Unde 9. Birthplace (State or Foreign **Funeral** 1 M 2 T NEW YORK Months Days Hours Min. 95 Yrs. Director 136-07-7616 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director MD. CHARLES LA PLATA Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1005 NORFOLK DRIVE 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify. þ Specify: WHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM HOWARD BLAKE ANNA OLGA JANKOWITZ ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAN BRENNAN-SON 1005 NORFOLK DR. LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o o 1X Burial 2 Gremation 3 Removal from State TRINITY MEM. GARDENS 11-30-09 WALDORF, MD. 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. LA PLATA MARYLAND 20646 23a. Part1. Enter the disease, or complications of at caused the death. Do no enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one callse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of) **Examiner** NEUMONTO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed and I-trai Due to (or as a consequence of) attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 065 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 □No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 🗆 No 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 inpatient Certification: To 2 ER/Outpatient 3 DOA 27. May er of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 □Yes 2 □ No investigation veral Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUL 710 SONG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 Registrar

3 DHMH 17 Rev 1/2001

N: 22936

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 38384 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 19, SHIRLEY STANLEY BRIDGES Nov. 2009 7:30 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1612 Cynthia Court Jarrettsville Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-30-0139 Yrs. 88 Director Canada Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. tnside City Limits 28a-f show ed other than "natural", or itema 23s or 28s-f showevent, the Medical Examiner must be notified at 1 ☐ Yes 2X No MD. Directo Harford Jarrettsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1612 Cynthia Court 21084 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filled within 72 hours after onent of Heelth and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or Ital 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) College (1-4or 5+) Keypunch operator Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stillman Stanley ဨ Gladys Stanley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 084 19a. Informant's Name/Relationship (Type, Print) (Son) William A. Bridges 3637 Anderson Jarrettsville, MD. Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Nov. 24, 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 □Donation 5 □ Other (Specify) Cemetery Bazman Bozman, Maryland 2009 21. Signature of Funeral Sanda Lip ns 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Hoe Jarrettsville, Maryland Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that calls a dy e death, shock, or heart failure. List only one cause on earline. Do not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Injury) that initiated events resulting in death) Last Due to (o Examiner the attanding physicien and ched for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Yes 20 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ å 1 Yes 2 No 3 Probably 4 Nhknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes P No certificate 1 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 Yes 20 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ this s efter death.
Il Diractor: After this
id in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of tntury 28d. Describe how intury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c/License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of 132th (flem 23a) (Type, Print) 7600 OSLER DR 5-411, TOWSON, MD 21204 AKKAD, M.D. F,

Registrar

State

31. Date filed (Month, Day, Year)

DEC O

6

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOVE MODI Year BENTON 6:53 PM JUDITH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death JOHNS HOAKINS BAYVIEW MEDICAL CENTE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Hours Min. (Month, Day, Year, Country) Maryland **Director** 1943 June9 218-42-0697 66 Usual Residence of Decedent or 28a-f show notified at Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland Baltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 3818 Elmely Avenue 21213 U.S.A. 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Yes 2 X No þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Specify.White "natural". 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry 12 should be filed www.ath and Mental Hygiene.
m 27 is marked other than "n maric event, the Mer (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Komorowski Margaret Shepherd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Patricia L. Hirth/Sister 1340 Sterling Drive, Troy, Ohio 45373 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State ArdentCremationservices 4 Donation 5 Other (Specify) Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPERTENSION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner > 10 years DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) sician and burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav 4 \square Pregnant at time of death the 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> of Vital Records, HYPERCHOLESTEROLEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy DRONACU certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural Division 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Phylicinn: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Expression of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Jursy Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 30. Name and add neted cause of death (Item 23a) (Type, Print) person who con MD Work 4940 EASTERN AVENUE BALTIMORE ms 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 9

		1	State Registrar				Cer	tificat	e of L	Death	1	В	leg. No				
	7 1		Decedent's Name (Fire	st, Middle, Las	(1)							2. Date of Dea Month	ith Da	v	Year	3. Time of	f Death
	Physicia /Medic				Ruth Gi	bson B	ryson]	Novembe			009	1930	РМ
	Examin		4a. Facility Name (If not	institution, give	street and num	ber)		4b. City,	Town, or	Location	of Death		4c.	. County o	of Death		
			516 Delawa	re Ave	nue				kton					Cec			
薄	Funeral Director		5. Social Security Number 218-18-960	4	ex □M 2∏F	7. Age (In yrs 87	. last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Birth (Month, Day March 1	Year)	922	9. Birthp Coun Mai	olace (State on try) ryland	or Foreign
			Usual Residence of Dec														
	ylan		10a. State 10t	. County		10c. C	ity, Town or Lo	cation							1	0d. Inside C	2 No
	B Ma	cto	Maryland	Ceci1			E1kton										2 140
	or 28	Director	10e. Street and Number					10f. Zip						tizen of W		•	
	23e		516 Delawa	re Ave					1921					nite		ates can Indian,	
	tams	Funerai	11. Marital Status		12. Was Dece Armed For	ces?	J.S. 13.	Was Dece If Yes, spe	dent of H	ispanic Oi in, Mexica	rigin? (Spec in, Puerto F	cify Yes or No- lican, etc.)			k, White,		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23e or 28e-1 show other traumatic event, Ita Medical Exeminat must be invitibled at	þ	1 Never Married 3 Never Married 4		1 ☐ Yes If Yes, Give Year or Da	e		1 🗆 Yes	2 X) No	Specify	·:			Specify:	Wh	ite	
5-0	72 h	Completed		Decedent's Ed nly highest gra	ducation de completed)		16a. Dece (Give	kind of wo	al Occup	ation during mo	st of workin	rg	16b. K	(ind of Bu	siness/In	dustry	
2	hen.	d m	Elementary/Secondar	y (0-12)	Cotfege (1-	-4or 5+)				')				Tn H	or O	wn Hom	20
2	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, IL. II.		17. Father's Name (First	t Middle last			110	memak	er	18. Moth	ner's Name	(First, Middle,				NII IIOII	ie
anc	ntal hed of	Be	James D. C							Res	ssie H	E. Lync	h				
Z	should be and Mental marked o umatic eve	ဥ	19a. Informant's Name/		Type, Print)		19b. Mailir	ng Address	s (Street			Route Numbe		or Town,	State, Ziç	Code)	
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ē,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tre once.	1	20a. Method of Disposit	ion		20h	Place of Disno	sition (Na	me of		Novem	ate		ocation ~	City or To	own, State	
Baltimore,	Pages nent of I snt: if its ary or o		1 X Burial 2 □ Cr 4 □ Donation 5 □			State No	cemetery createry creater orth Ea ethodis	st Com	otor	- I	21, 2			North	h Ea:	st, MI)
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			23a. Part1. Enter the d shock, or heart fai	isease, or com	plications that co	aused the dea	ath. Do not en	ter the mo	de of dyin	ig, such a	s cardiac o	r respiratory ar	rest,			Approxima Interval Be	etween
	Physician		Immediate Cause (Final disease or condition		- 1	emen	lig &	nds	taxe						1	Onset and Unha	CVO'H
	/Medical		resulting in death)		Due to (or as a conse	equence of):										
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Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician	in the past 12 mor	nths?	4⊡Pregn	irth 2□Fe ant at time of		□Ectopic p □ Other (s		<u> </u>				Mor	nth	Day	Year
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Division of Vital Records,	Attending Physician: r death. ector: After this certifica by the funeral director,	on:	27. Manner of Death 1 ☑Natural 5	i ☐ Pending	28a. Date (Mon	of fnjury th, Day Year)	28b. Time of finjury		28c. Injui			28d. Describe	how inj	ury occurr	ed		
sio	tendi leath. tor: /	cati	2 Accident 3 Suicide	investigation Could not t		at Indian At	<u> </u>	М		Yes 2[28f. Location (Street	and Numb	er or Ru	ral Route No	ımher
Ξ	or At	Certification:	4 Homicide	determined	28e. Place buildi	ng, etc. (Spe	home, farm, st	reet, racto	гу, опісе		'	City or To			er or nur	ai /100(8 140	mber,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier 1[3	Certifying P	hysician: To the	best of my k	nowledge dea	th occurre	d at the ti	me date	and place.	and due to the	cause(s) and ma	anner as	stated.	
	Hos 24 hc Fun etely	edical	(Check only 2 one)	Medical Exa	miner: On the b	asis of exami ner stated.	nation and/or it	nvestigatio	n, in my	opinion, d	eath occurr	ed at the time,	date ar	nd place,	and due	to the cause	(s)
	oth oth ompl	₩.	29b. Signature and title	certifier						se numbe						, Day, Year)	
	- > F 0		>	levella	Cer sa	rd			DO	023	322	_		//.	18	2000	7
	18		30. Name and address	of person who	completed caus	se of death (It	em 23a) (Type	Print)	+ /	-01	Ten B	102193			-		
	\	9	31. Date filed (Month, I	Day Year	22 0	legistrar's Sig	inature	7 -1	1 -		/ 1		7.				
	Sta Regist		TEC 0.9		L	A A	books	9									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Katherine Elizabeth Bryant /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye Apr 14, Security Number **Funeral** Min. Year. 1 □ M 2 □ € MD 212-24-0527 1926 Director 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show iral", or items 23a or 28a-f show Allegany MD Cumberland 1 □ Yes 2 □ No Directo and 2 should be filed within 72 hours after death with the leath and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Lafayette Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ 💑 Completed by Specify. Specify. 3 ■Widowed 4 ■ Divorced white 'natural", other treumatic event, the Mudical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than amy Injury or other treumatic event, Item 2016e. Elementary/Secondary (0-12) College (1-4or 5+) WMHS- Memorial housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cloyd V. Owens Dora A Smallwood Owens မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Moore MD 21502 daughter 718 Lafayette Avenue Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 11/20/2009 Cumberland MD 4 Donation 5 Dother (Specify) 21. Signature of Fun all Pervice License 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à icate has been sig 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 E No 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar

State

31. Date filed (Month)

Day,

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 38388 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Connelly Margaret Suzanne 5:15 P M Nov 14, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1017 Wiltshire Drive LaPlata Charles 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Months Hours 232 36 4406 81 Oct 14, 1928 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinating as 1 □Yes 2 ¬No Director LaPlata Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1071 Wiltshire Drive 20646 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Art No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify. <u>ک</u> 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Community Hospital College (1-4or 5+) Elementary/Secondary (0-12) Greater Southeast R.N. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h and 2 should be Edith Silcott John Anthony Overton, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other tranonce. (Daughter) 1017 Wiltshire Drive, LaPlata, MD 20646 Karen Ann Connelly 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Kurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 11/19/2009 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Lice Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 \(\subseteq \text{ Ectopic pregnancy} \) in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 🗆 No 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier ness of person who completed cause of death (Item 23a) (Type, Print) WISOTSA 12070 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 17 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dorothy Arbutus Cutter November 2009 11:15 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Railroad St. Midland Allegany 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 31 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs, last birthday) Months Days Hours West Virginia 219-28-9497 1 □ M 2 🕅 F 76 Aug. 1933 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Midland MD. 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14817 Railroad St. 21542 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 ☐ No Specify: 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sheriffs Office Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Pugh Mae Lawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2161 Green Lantern Rd, Lonaconing, Maryland 21539 Vicki Clark/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Barton, Maryland Laurel Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Boal Funeral Home Church St, Westernport, Maryland 21562

Physician /Medical Examiner

Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once.

Physician

/Medical

Examiner

Funeral

Director

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items 23a

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and the burial-transit as nse signed by the a d be detached f certificate has birector, page 2 s ours after death. neral Director: Ai filled in by the fu

the Hospital or Attending Physician: The law requires that the death certificate be executed

this

Division of Vital Records, P.O. Box 68760,

	shock, or heart failure. List only	one cause on each line.		to the death of the same of th	ac or reophatory arroot,		Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as consec		ELL CARCI	NOMA	ε	NE Y
Examiner	Sequentially list conditions, in any, leading to miniculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consecutive for a con					
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fetr 4 Pregnant at time of 9 Unknown	al death 3 ☐ Ec	topic pregnancy ner (specify)		23d. Date of delive	ery Day Year
2	Part II. Other significant conditions of	ontributing to death but not res	sulting in the under	ying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death? ably 4 ☐ Unknown
Completed					24a. Was an autopsy performed	prior to con death?	psy findings available npletion of cause of 2 No
å	25. Was case referred to medical examiner?				eath (Check only one)		
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing	Home 5 Residence	6 ☐Other (Specifi	y)
ation:	27. Manner of Death 1		28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in		
Certification: 10	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street,	factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
Medical	29a. Certifier 1 ✓ CertifyIng Ph (Check only one) 2 ☐ Medical Exam	nysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occation and/or investi	curred at the time, date and place gation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
Ž	29b. Signature and title of certifier	^ /		29c. License number	29d. I	Date signed (Month,	Day, Year)

State Registrar wand

32. Registrar's Signature

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 November Elizabeth Corcoran /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 21280 Lexwood Court Lexington Park 5. Social Security Number f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕱 F **Director** 577-42-8582 75 12/24/1933 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. It filem 27 is marked other than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat roust be nutilised at other. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits St. Mary's 1 ☐ Yes 2 ☑ No Director Maryland Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21280 Lexwood Court 20653 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Appliances 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Sparrow Everett Shurr ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Corcoran/Son P.O. Box 439, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/16/2009 | Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee ▶ Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Acute M I /Medical Due to (or as a consequence of): **Examiner** Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Severe Aortic Stenosis and Due to (or as a consequence of) Box 68760. Physician/Medical Hyperlipemia 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) <u>О</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Chronic Smoking, Conjestive Heart Failure 1 🗹 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home SQResidence 6 Other (Specify) Hospital 1 Yes 2 No 1. Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09 D 622/3 13 ponce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22650 Cedar Lane Court, Leonardtown, MD 20650 Suresh Patel, M.D. 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State NOV 1 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** onner 22: 58 Nove inber 2009 ale /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth
(Month, Day, Year)
April 1,1941 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign
Country) 5. Social Security Number last birthday 68 68 **Funeral** Days Hours 1 □ M 2 X F New York Vrs .08-32-1400 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 28a-f show at 1 ☐ Yes 2 X No Maryland Calvert Prince Frederick Director other traumatic event, the Medical Examiner must be notified 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ŏ USA or items 23a 20678 6032 Daybreak Drive Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Hote1 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adeline Lindbeck Victor C. Lewis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau 6032 Daybreak Drive, Prince Frederick, MD 20678 Edward J. Conner/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State November 9 Charlotte Hall, MD Brinsfield-Echols Crem. 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., of Funeral Sevice Licensee 21. Signa PO Box 128, Charlotte Hall, Maryland 20622 MO0817 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SAPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or moury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Live birth 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 1 🗌 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) 28a. Date of Injury
(Month. Day Year) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) RES 000 November 17 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(-(00)

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year)

72. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Registrar #20b, FH, TCHD, pha 11/17/09 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Day le **Physician** 0821 AM /Medical cility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner extown oital VEIC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F Yrs 082-34-9546 10-01-1944 **Director** NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Md. Worton 10g. Citizen of What Country? USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Unknown 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n: any injury or other traumatic event, in Medicone. Operator Elementary/Secondary (0-12) College (1-4or 5+) Ommunication Personnel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glenn ျှ rews Unknows 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Still Pond Creek Rd. Flakes Norton, Md. 21678 Diana Care given 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition Burial 2 Crematid 3 Removal from State 4☐Donation 5☐Othe VA Cemetery Signature of Fureral Sen 22. Name and Address of Facility Bennie Smith Funcial Home Rd 298, Chestertown hman Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that Dusshock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest line. Immediate Cause (Final Physician prongry disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Heart tailure on gestive Due to (or as a consequence of) Box 68760 physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ours after death.

neral Director: After this
y filled in by the funeral di Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200° 3-RS s of person who completed cause of death (Item 23a) (Type, Print) DWN ST

DHMH 17 Rev 1/2001

Registrar

VA-RS

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gistrar's Signature

CHESTER TOWN

09-08919 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 38393 David Wayne Cissel State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar I. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day November 16, 2009 Medical Examiner 2225 hrs David Wayne Cisse1 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director Countaryland 12/28/1962 216-88-3484 1 X M 2 F 46 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 23a or 28a-f show notified at once. MD Calvert Huntingtown Pages I and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 4335 Rhett Butler Court 20639 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? White, etc. 1 Never Married 2 X Married Yes 2 X No 9 Widowed Divorced If Yes. Give Year Yes 2 X No specify. Specify: white narked other than "natural", event, the Medical Examiner 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 4 graphic artist Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumarke security. self employed 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gordon Helen Arlene Eugene Cissel Corbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4335 Rhett Butler Court, Huntingtown, MD Donna D. Cissel, wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 X Cremation 3 Metropolitan Crematory 11/20/2009 Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licens Rausch Funeral Home. 8325 Mt. Harmony Lane, Owings, MD 20736 Approximate Interval Part I. Enter 🛩 lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a Hypertensive atherosclerotic cardiovascular disease Immediate Cause Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause Dusita (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED attending physician or use as the burial 23a,27,permE, g898 12/4/09 TT Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown has been si 24b. Were autopsy findings available

the Hospital or Attending Physician: The law requires that the death certificate be executed Records, Division of Vital this 24 hours after death.
e Funeral Director: A etely filled in by the fu

Completed 24a. Was an autopsy performed? certificate h Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: Other: Inpatient 2 V ER/Outpatient 3 DOA Residence 6 Nursing Home 5 1 V Yes 2 No After the 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a)

OCME

Day, Year

MAY 2.0 2009

Assistant Medical Examiner

Carol Allan, MD

31. Date filed (Month,

prior to completion of cause of

No

death?

November 17, 2009

Yes 1 1

Other:

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

To the

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bilbie Relva Cox JR 2009^{Year} November 4:12 AM^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1621 Defense Highway Gambrills Anne Arundel 5. Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours Min 10/22/1943 Director 216-42-8943 66 MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Gambrills 1 Tyes 2XXNo 10f. Zip Code 21054 10e. Street and Number 10g. Citizen of What Country? USA **Funeral** I 1621 Defense Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Was Deceue... Armed Forces? 1 X Yes 2 No 68 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3XXWidowed 4 ☐ Divorced Specify Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Helen Law Bilbie Relva Cox SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Jane Cox 1106 Bay Ridge Ave Annapolis, MD 21403 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Atlantic Crematory 11/05/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyreral Service Licensee 22. Name and Address of Facility Date Hardesty Funeral Home P.A. 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 G g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 X No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Natural injury Accident Investigation Suicide 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical

Physician/ Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 nin 24 hours after death.

the Funeral Director: After this certificate has been signed by tapleted filled in by the funeral director, page 2 should be detact To the within 2
To the F

Baltimore, Maryland 21215-0036

State Registrar DHMH 17 Rev 7/2009 29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) av I B. Berez mb 2225E Defe

certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ense Hny, Crofton,

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 38395 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2009 LORRAINE M. CROMER 0430 1. 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HIOMICO MEDIENC SAUSBILL Keg/ONAL If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. JULY 1, Director 65 1944 DELAWARE 222-26-3242 Usual Residence of Decedent 2.2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exactions and the motified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Yes 2 □ No DELAWARE SUSSEX BETHANY BEACH 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 31339 CORAL COURT 19930 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: WHITE 3 Widowed 4 NDivorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ELECTRONICS COMPUTER ANALYST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should by timent of Health and Mentatant: If Item 27 is marked RAYMOND MCCABE ပ FLORENCE CAREY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID THOR CROMER/SON 130 BOWDOIN ST., APT. 608, BOSTON, MA 02108 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department o
Important: If i
any injury or
once. = 5 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 Donatten 5 ☐ Other (Specify) CREMATORY OF DELMARVA 11/12/09 DELMAR, DELAWARE 21. Sign vure Euroral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** bacterial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner congestive Sequentially list conditions, if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 MNo 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and it 29c. License number 29d. Date signed (Month, Day, Year) 1)005993/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAPROLL St. SAlisbury md. 21801 HOFMANN MD 100 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward Charles Cage /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS-R LEGA 8. Date of Birth (Month, Day, Ye May 14, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 4 1<u>925</u> 1 → M 2 □ F Months Days Hours Min 219-14-5620 MD Director 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Montal Event must be redified at once. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 135 N. Mechanic Street, Apt. 3 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify. þ Specify: WWII 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Exterminator Hygienic Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Claude M. Cage Myrtle V. (Wolfe) Cage ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Shrout daughter 14041 Cedarwood Drive, Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 11/28/2009 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STAGE ISCHEMIC CARDIOMYDPATH END ONE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by RENAL 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed 2₽No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: A lletely filled in by the fu 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

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Registrar's Signature

09-09144 Kelly Cooper

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ November 24, 2009 1810 hrs Kellv Lynne Cooper **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick 5240 Westview Drive Apt. 324 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Foreign Washington Country) D.C Min Hours Months Days Director 215-21-0398 M 2X F 32 May 27, 1977 D.C. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Frederick 1 Yes 2 X No Md. Frederick Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 5240 Westview Drive, Apt. 324 21703 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 y Married Yes White Yes 2 X No specify: Specify. 3 Widowed Divorced Give Yee 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ | Hygiene. ed other than "r t, the Medical E Baltimore, MD 21215-0036 Own Home 0 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Wayne Jordan Cynthia Newton of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t: If item 27 is mother traumatic 17 Garfield Court, Gaithersburg, Md. Cynthia Jordan / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place) Burial 2 X Cremation 3 Removal from State 11/28/09 Metropolitan Crem. Alexandria, Va. Donation 5 Other Specify: 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee ach P. O. Box 5038, Laytonsville, Md. 20882 23a. Part I. Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and Death failure. List only one cause on each line /Medical Dilated cardiomyopathy Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical X UNPENDED AMENDED attending physician or use as the burial -23a,PII,27,perME, g899 1/6/10 TT that the death certificate be Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Yes 2 No 3 Probably 4 V Unknown Hypothyroidism Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of icate has by page 2 sh death? performed? ✓ Yes 2 1 V Yes this certificate 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other₄ Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Hospital or Attending 24 hours after death. Certification: 1 X Natural Yes 2 Director: Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide (Specify) Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 25, 2009 O.C.M.E. 111. 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar 32 Registrar's Signature

Laron Locke MD. 31. Date filed (Month Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Ye ar **Physician** HAROLD WALTER 23 2009 CHEYNEY, III NOVEMBER 8:23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 165 Main St. Cecil Warwick If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Hours Days 1X M 2 □ F Director 218-74-4703 44 Aug 8 1965 Delaware Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ir than "natural", or items 23a or 28a-f shire Wedical Evaniration to notified 1X Yes 2 □ No Director MD Cecil Warwick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 165 Main St. 21912 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐Yes 2 ☑ No White 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, Im. M. Elementary/Secondary (0-12) College (1-4or 5+) Crabbing, Fishing Commercial Waterman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Walter Cheyney, Jr. Dorothy Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Cheyney (wife) Box 210 P.O. Warwick, MD. 21912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 11/28/09 Cecilton, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 21635 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in de (1) **Physician** 179110 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year Day 5 Other (specify) signed by the a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 icate has been si , page 2 should b 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 certificate 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: A letely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hor To the Fune completely fi (Check only 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Renee Perkis, 349 E. M.D. Pulaski Hwy, Elkton, MD. 32. Registrar's Signature State 2 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Juanita Cyrus- Hayes 12:101 M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice at Northwest Randallstown Baltimore Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** 1 □ M 2 💢 F Days Hours **Director** 50 404-86-5518 July18,1959 Kentucky Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at X☐Yes 2☐No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8420 Maymeadow Court Completed by Funeral 21244 H 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 than "natural", or 1 ☐ Yes 2 → No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ages 1 and 2 should be filed within of Health and Mental Hygiene. It: If item 27 is marked other than "y or other traumatic event, It when Elementary/Secondary (0-12) College (1-4or 5+) Defense Contractor <u>Administrative Asst</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Welbon Monroe Pages 1 and 2 should hen ment of Health and Men ပ Juanita Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 4312 Vintage Ivy Lane, Owings Mills Maryland <u>Vanessa Ringgold</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Borden Crematory 11-23-09 Louisville, Kentucky 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licenses muchael marguelle 6009 Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🖳 🗐 🐪 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No eral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

State

Registrar

29b. Signature and title of certifier

MS Kajapahse M.D

NS. Rajapakse, MD.

31. Date filed (Month, Day, Year) **DEC 0 2 2009**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

00057465

25 Main St., Suite 260, Reisterstown, MD. 21136

29d. Date signed (Month, Day, Year)

11/17/109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 14, 2009 7:30PM Mary Joyce Craig /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Manor Care Ruxton Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2√2 F Months Days Hours Min. **Director** August30,1915 078-14-8381 94 New York Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7001 North Charles Street 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🌠 No Specify: White Specify: Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If flem 27 is marked other the any injury or other traumatic event, the once. 12 Editor Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phoebe Knapp George Edwin Mineah ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503Sunbrook Lane, Pikesville, Maryland 21208 Carolyn Hartloff/Daughter 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11-16-09 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. muhael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 █ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 2 No 1 □ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation Iniun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 filled in by the funeral within 24 hours a To the Funeral D

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Z-+

Ziael

30. Name and address of person who completed cause



of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

037570

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 10, Elizabeth November 2009 7:30 P M Stella Dasch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ijamsville If Under 1 Year | If Under 24 Hrs. 3488 Augusta Drive Frederick Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗓 F Months Days Hours Min. Yrs. 9. Director 163-34-5561 66 1943 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Wedical Exaction must be notified at 1 ☐ Yes 2 🕅 No Director Maryland Frederick **Iiamsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3488 Augusta Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene.
27 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) City of Gaithersburg Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic eveni one. Be Robert Regal Lena Shoemaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William L. Dasch - Husband 3488 Augusta Drive, Ijamsville, Maryland 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematorium 11/14/2009 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Fune al Service Lice Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5--756 /Medical Due to (or as a consequence of): Examiner 60 D day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> icate has been si r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 22 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No 1 ∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ∐Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70364 31. Date filed (Month, Day, Year) 32. Registrars Signature State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 38402 State
Registrar Amend#11perfuneralhomecchd1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:15P M Medical Nov 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital CLinton Prince George's 9. Birthplace (State or Foreign Country) Maryland **Funeral** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours (Month, Director 50 8038 Dec Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any mjury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 VNo MD P.G Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9616 Small Drive 20735 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceuent Armed Forces?

1 ☐ Yes 2 ▼ No 14. Race - American Indian, Black, White, etc. 1- Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify. Black 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Management Program Analist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Calvert L. Hicks Catherine E. Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Nelson (Daughter) 1108 Foster Holly Court, Denton, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Resurrection Cemetery 11/19/2009 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Sanaty of Funeral S-22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 09 exandria Ferry Road, Clinton, MD Inter the disease, or complications that caused or hear failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year the 9 Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy , page in 24 hours after death.

the Funeral Director: After this certificate I
pleted filled in by the funeral director, page performed? Yes 2 No 1 Yes 2 No 25. Was case referr examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 LX No ျပ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work' 2 Accident
3 Suicide
4 Homicide Investigation 1 Tes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and Nile 29d. Date signed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 Celia Dietz November 10:48 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2XXF Hours Min Country) Director 054-10-0461 Usual Residence of Decedent 23a or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hyglene.

is marked other than "natural", or items 23a or 28a-f sho Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No MD Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fannie Goldstein David Greenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5913 Willow Knoll Drive Rockville, MD 20855 Amy Turner / grand daughter 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 5 Ther (Specify) National Crematory Falls Church, VA 4 Donation 11/10/2009 21. Signature uneral 22. Name and Address of Facilly anzansky-Goldberg Memorial Chap. Inc amie Arthurs M01163 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, pr heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): **Examiner** Entero-Vesicular Fistula unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 **X**No 1 Yes 2 9 Unknown Yes 9 Unknown been signed by a should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lung Mass the Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hyper Kalemia 24a. Was an cate has t performed? Yes 2 No certificate 1 ☐ Yes 2XXNo Division of Vital Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 2**X X**No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XX Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after deat Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practices: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated. (Check only one 2 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 31027 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Mon)

8606

egistrar's Signature

or Print in Black Indelible Ink Ensure All Conies Are Legible

		1	For State Registrar	State of Mary	land / Depa		lealth and N	/lental Hy			3840
ı	Physicia	ın	1. Decedent's Name (First, Middle, Last, Joseph Lawrence					2. Date of De Month Novembe	Day	Year 2009	3. Time of Death 3:18 p.m
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. (County of Death	1
			St. Mary's Hospita	1		Leonard				. Mary'	
	Funeral Director		5. Social Security Number 6. Se 12 13-96-4912	1 M OF F	yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di 02/02/	rth ay, Yea <i>r)</i> 1964	Co	nplace (State or Foreig untry) r land
	or or		Usual Residence of Decedent		0: 7						10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show all injury or other traumatic event, If Item and Item is not that items once.	- 1	10a. State 10b. County Maryland St. Mary		c. City, Town or Lo allaway	ocation					1 ∐Yes 2 XN
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Co	untry?
	th wit	<u>a</u>	44970 Serenity Far	m Lane		20620				ed Stat	
	dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp Jan, Mexican, Puerto	pecify Yes or No Rican, etc.)	0- 1	 Race - Ame Black, White 	
036	urs after al", or It	by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No					hite
- 2	72 ho	etec	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	edent's Usual Occu	pation during most of work d)	king	16b. Kir	nd of Business/	Industry
2	thin se.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					D. 6	1 . 0 . 1	
2	ed wi	ပ္ပ	12		Groc	ery Clerk	18. Mother's Nam	o /First Middle		ail Sal	es
nd	be fill d oth even	Be	17. Father's Name (First, Middle, Last)							ournamo)	
yla	should and Men s marke umatic	은	Kenneth R. Dement				Shirley t and Number or Ru			Town State	Zin Cada)
/ar	2 sh and Is m		19a. Informant's Name/Relationship (7								Lip Code)
6	and Health Im 27 her t		Lisa W. Dement/Wi	te			Callaway	Date	20620 20c. Lo	cation - City or	Town, State
000	Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	nemoval nom state		osition (Name of ematory or other pla	1				, Maryland
Baltimore, Maryland 21215-0036	permit. Po Departme Importani any Injury once.		4 □ Donation 5 □ Other (Specify 21. Signature of uneral Seque I Con		2		ess of Facility Br	insfiel	d Fun	eral Ho	ome, P.A.
_	90 E # 9		Edward N. Brins	field, Jr.	M00052 2	2955 Holl	ywood Roa	ad, Leo	nardt	own, MI	20650
(Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the one cause on each line. a. Due to (or as a company)	al t	orter the mode of dy	ing, such as cardiac	e de	arrest,	2	Approximate Interval Between Onset and Death
	Examiner P P P P P P P P P P P P P P P P P P P	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Sta Due to (or as a c	onsequence of):	PICP	licus				
68760,	icate be executed physician and the burial-transit	cal	resulting in death) Last	Due to (or as a c	onsequence of):						
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnal	ncy			23d. Date of de Month	llivery Day Year
σ.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying cause g	iven in Part I.		d tobacco		o the cause of death?
of Vital Records,	The ate h	Completed						24a. Wa au pe 1 □ Yes	topsy rformed?	prior to death?	utopsy findings availal completion of cause of s 2 \sumbox No
/ita	iysiclan: The lis certificate director, pag	Be	25. Was case referred to medical examiner?	Managhali, & P		10	26. Place of De	ath (Check only	y one)		
¥		2	1☐ Yes 2DNNo		2 ER/Outpat	ent 3 DOA		_		6 ☐ Other (Sp	ecify)
ion	nding Path. r: After i		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		/ear) 28b. Time Injury	/ W	ury at ork? □Yes 2□No	28d. Describ	e now inju	ry occurred	
Division	il or Atte after dea Director	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, s (Specify)	street, factory, office		28f. Location City or 7	(Street ar Town, State	nd Number or F e)	Rural Floute Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier 1 CertifyIng Ph (Check only 2 Medical Examone)	nysician: To the best of niner: On the basis of e and manner state	xamination and/or	ath occurred at the investigation, in m	time, date and plac y opinion, death occ	ce, and due to to	he cause(s ne, date an	s) and manner ad place, and du	as stated. ue to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	ala		29c. Lice	nse number		29d. Da	ate signed (Moi	nth, Day, Year)

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 47066 D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22650 Cedar Lane Court, Leonardtown, MD 20650 Avani D. Shah, M.D.

State Registrar

31. Date filed (Month, Day, Year) NOV - 6 2009

Dement

Joseph Lawrence

State of Maryland / Department of Health and Mental Hygiene State Registra Ammended #10e, d1b, 11/09, SMC Certificate of Death 2. Date of Death **Physician** 12:30 P_M Veronica Catherine Dixon 4, November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown Mary's St. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🔀 F 218-24-2285 85 Director April 21,1924 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the "Medical Extrainer ILISE the netitinal art once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 ☑ No Maryland St. Mary's Hollywood 10f. Zip Code 10g. Citizen of What Country? 1094 Atrest and Cumberks 44234 Cox Landing Road 20636 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: White þ Specify. 3 X Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Switchboard Operator 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ John I. Dorsey Annie M. Readmond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Evelyn Dryden / Daughter 22322 Cedar Street Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State November 10 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Charles Memorial Gardens Leonardtown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.A. Kennetk P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director; After this certificate has been signed by the attending physician and Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a ∐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant nditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director; After this certificate has filled in by the funeral director, page 2.3 autopsy performed? 1 ∐ Yes 2 **N**O 1 □Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐺 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖥 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and ittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) 30. Name and ad ress of person who domi James Jarboe, M.D. 21585 Peabody Street Leonardtown, MD 20650 Day, Year) 31. Date filed (N 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:08 p.m. 4, 2009 November Kathryn Harbison /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Leonardtown St. Mary's St. Mary's Nursing Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F 87 08/29/1922 North Carolina Director 240-20-4719 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland St. Mary's Dameron filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20628 United States Funeral 49595 Diamond Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Banking Bank Teller marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fil th and Mental H 7 is marked ott Be Kathryn Potts Abernathy Charles Waighstill Harbison ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Sandra D. Sweikar/Daughter P.O. Box 9, Dameron, MD 20628 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 11/06/2009 Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cre Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as conclude or respiratory arrest, shock, or heart failure. List only one cause on each in e. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to I **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examine be executed and burlal-tran Due to (or as a consequence of): Box 68760. Physician/Medical the ası attending for use a 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ☐Yes 2 No P.O. ed by the a detached f 9 Unknown 9 Unknown signed by t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, è 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t performed? Yes 2 2 No 2 🗆 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After t (Month, Day, Year) Injury Natural 5 Pending investigation after death, I Director: Af ed in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 24 hours a Funeral L Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of destifie ē

Registrar

State

30. Name and

James

dress of p

31. Date filed (Month, Day, Year)

Jarbbe

M.D

24035 Three Notch Road, Hollywood, MD 20636

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State 9b Registrar 38407 Certificate of Death Reg. No. FH, TCHD pha 11/12/09 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month 3. Time of Death **Physician** Day DENNIS P. DILLON NOVEMBER 6 2009 11:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 29447 LISA DRIVE TALBOT EASTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Voar 1**X**M 2□ F Months Yrs Director 56 218-58-2333 08/07/1953 MARYLÁND Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Exeminar must be notified at Director 1X Yes 2 □ No 28a-f MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö filed within 72 hours after death with 23a 29447 LISA DRIVE 21601 Funeral U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Maryland 21215-0036 9 If Yes, Give Year or Dates: 1 ☐ Yes 2 No 2 Specify: WHITE "natural" Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) : 1 and 2 should be filed wi f Health and Mental Hygier tem 27 Is marked other th ROOFER RESIDENTIAL CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES KENNETH DILLON ELIZABETH BOWLE 19a. Informant's Name/Relationship (Type. Print) Age Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NICOLE E. DILLON/DAUGHTER 321 EAST FULTON ST., FARMINGTON, IL, 61531 If Item 2 or other Baltimore, 20a. Method of Disposition
1 → Burial 2 → Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If It any Injury or o 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 11/10/2009 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lower failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis CMKSA **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner RV. h e Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physiclan: The law requires that the death certificate be executed and burlal-trar Due to (or as a consequence of): attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No detached 9 Unknown nas been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page certificate 1 □Yes 2 🙀 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760. To the Hospital or Attend within 24 hours after death To the Funeral Director: completely

12S 3

> State Registrar

31. Date filed (Month Year) NOVUY

29b. Signature and title of certifier

2

(Check only one)

Da # 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eastn. Md 21601

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

N124198

29d. Date signed (Month, Day, Year)

DELEAN - BOTKIN

11/9/2009

SUSAN

law requires that the death certificate be executed Box 68760 P.O. Division or Vital Records,

physician

certificate has

After this

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Maryland 21215-0036

Baltimore,

State

within 24

30. Name and address of person who leted cause of death (Item 23a) (Type, Print) Brankle 0 31. Date filed (Month, NOV

and manner stated.

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

21413

State Registrar

4

VA

SURESH 31. Date filed (Month, Day Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

KARTHIK

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

NOVEMBER 16, 2009

29c. License number

Barkel

RES-000

			101	epartment of Health and M	, ,	000000000000000000000000000000000000000
			Registrar	Certificate of Death		vo. 2009 38410
	Physici	an	Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
11/4	/Medic		Lois Delaplane 4a. Facility Name (If not institution, give street and number)		November	
	Examin	er		4b. City, Town, or Location of Death	4	4c. County of Death
	Funeral		Northampton Manor Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Frederick If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederick 9. Birthplace (State or Foreign
	Funeral Director			Months Days Hours Min.	(Month, Day, Yea	Country) 1935 Pennsylvania
	ъ		Usual Residence of Decedent		Dept. ZZ,	
	rylan	_	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Ba-f s	cto	Maryland Frederick	Frederick		1 ☐ Yes 2X No
	ith th	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, it a Medical Examinar must be rodified at	rai	7015 Basswood Court	21703		nited States
	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	I', or	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 【XNo Specify:		Specify: White
Ö	thou attura	peq	15. Decedent's Education 16a.	Decedent's Usual Occupation	16b.	Kind of Business/Industry
215	in 72 in "in	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workir life. DO NOT use retired)	ng	,
21	d with giene er tha	Completed	+3	Organist		Religious
p	al Hy I oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	en Surname)
yla	should be f and Mental I s marked of tumatic ever	To	Clark Miller	Els	ie Merrym	an
Maryland	2 sho	5		Mailing Address (Street and Number or Rura		
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Mycdical Examiner must be retified at			4 Lemans Court, Fink		
0	Pages 1 nent of H ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	r, crematory or other place)		Location - City or Town, State
altimore,	it. Pa rtmer rtant:		4 □ Donation 5 □ Other (Specify) Stauff	er Crematory 11/10		rederick, Maryland
Ba	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service Licensee			Funeral Home rederick, MD 21702
			23a, Part Enter the disease, of complications that caused the death, Do n	<u> </u>		Approximate
	Physician		23a. Parture the disease. of complications that caused the death. Do no shock, or heart failure. Light only one cause on each line. Immediate Cause (Final	•	, roop, arony	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death) Due to (or as a consequence of	monior		1-2 Week
	Examiner			,		
	ב. ק	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury):		
	icate be executed physician and s the burial-transit	Examiner	that initiated events			
60,	be ex cian a	Ē	resulting in death) Last Due to (or as a consequence of):		
58760,	physi the I	dical	d		·	
×	ding se as		IF FEMALE: 23c. If yes, outcome of pregnancy			COAL Protect deliberary
Rox	death e atten d for us	sician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
9	t tes	Physi	1 Yes 2 No 9 Unknown	o Li o titol (openny)		
7. J.	s that	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ecords,	requires that veen signed b hould be deta		Hypertension		1 □ Yes	2 No 3 Probably 4 Unknown
ပ္က	law re las bee 2 sho	olete	Asthma		24a. Was an	24b. Were autopsy findings available
ř	The faw ate has bage 2 s	Completed	A .	(a. 0.1	autopsy performed?	prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
Vital	lan: artifica	Bec	Adam corcinima unknow 25. Was case referred to medical examiner?		1 ☐ Yes 2 ★ N (Check only one)	No 1 ☐ Yes 2 No
o -	hysic his ce I direc	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	oatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence	6 ☐Other (Specify)
ב ס	Ing P	on:	27. Manner of Death 1★ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Inj	ury Work?	8d. Describe how inj	jury occurred
<u>s</u>	tend leath. tor: / the fi	cati	2 Accident investigation	M 1 □Yes 2 □No		
DIVISION	or A after of Direc	Certification:	4 Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
_	spital		29a. Certifier Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, a	and due to the cause	e(s) and manner as stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Medical	(Check only Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occurre	ed at the time, date a	and place, and due to the cause(s)
	withi To t	ž	29b. Signature and the of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
			April	D0051643		19/09
(B		30. Name and address of person who completed cause of death (Item 23a) (I	ype, Print)		V 110 010
			31. Date filed (Month, Day, Year) 32. Register's Signature	Johnson Dr. F	rederi	ck MD 21702
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	harles		-
			THE STATE OF THE PARTY OF THE P	17		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kathryn C. DiMeglio Month 10:41P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TX F 179-18-4597 Months Days Hours Pennsylvania **Director** 91 ′1′9°1′8 Usual Residence of Decedent 28a-f shov 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 798 Eastern Point Rd. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔊 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes Yes, Give 1 Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced Completed Specify: White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ishould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) years Homemaker Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Phillip Gallagher Mary Quinan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 3500 Horseman Way, Davidsonville, MD 21035 Marsha A. Pfunder/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery! 11-9-09 Brentwood, MD rvic censee 21. Signatu 22. Name and Address of Facility George P. Kalas Funeral Home any 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Onset and Death 0 are disease or condition Medical resulting in death) Due to (or a onsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in dooth) (pot. Examine Due to for as a Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month Year should be detached 9 🔲 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 2 No Accident Investigation Suicide
Homicide Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who ted cause of death (Item 23a) (Type, Print) at State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 24 2009 $a^{\,\mathsf{M}}$ NOVEMBER DORIS LOUISE DEGROODT 7:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kent 31661 Well Bottom Rd. Galena Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 ▼ F 25 1938 148-30-9740 70 Dec. New Jersey Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Kent Galena the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 31661 Well Bottom Rd. 21635 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: ğ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 h (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Dental Office 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental h permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic ev Harry Reading Simmerman Dorothy Rainer Warren ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31661 Well Bottom Rd. Galena, Ralph S. DeGroodt (husband) MD. 21635 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages nent of I 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Kent Cremation 11/28/09 Smyrna, DE. 4 □ Donation 5 □ Other (Specify) of Funcial Service License 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 M00510 Approximate Interval Between Onset and Death 23a Part Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cau e (Final disease or condition resulting in eath) **Physician** Cerebral Aneurysm /Medical Due to (or as a consequence of): Examiner CVA Sequentially list conditions, if any, leading to immediate bauss. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Por Month Year 5 Other (specify) signed by the a ☐Yes 2 No <u>P</u>.0 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen Were autopsy findings available prior to completion of cause of death? s certificate has be irector, page 2 s autopsy The performed' 1 ☐Yes 2 ☐No 1 □Yes 2 X No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 1 🗌 Inpatient ပ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending F s after death. Division 5 ☐ Pending investigation 1 Natural nours after death.

neral Director: Ailled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Hospital 24 hours a e Funeral D LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number C10005656 11/24/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar William Covell, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

212 Carter Rd. Middletown, DE. 19709

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Maryla		epartment of F Certificate of I			giene Reg. No	2009	38413
Physicia	an	1. Decedent's Name (First, Middle, La		Dench.	field	-	2. Date of De Month	Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, giv				r Location of Death	Novemb		County of Death	1:18 A M
LXaiiiii	CI	8817 Adventure				kersville			Freder	ick
Funeral Director		5. Social Security Number 6. S 575-46-1733	6ex	s. <i>last birthe</i> Yr	Months Davs	If Under 24 Hrs. Hours Min.	(Month, Da	th y, Yea <i>r)</i> 4 , 1 9		place (State or Foreign ntry) ican Samoa
and		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town o	r Location				1	0d. Inside City Limits
Maryl I-f sho	tor	Maryland Frede	rick	•	Walke	ersville	·			1 TyYes 2 □ No
ith the	Director	10e. Street and Number			10f. Zip Code				en of What Coun	ntry?
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72 hours after death with the Maryland natural", or items 23a or 28a-f show Jeel Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0.5.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)		Black, White,	
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should be and Mental marked o	To E	Gus Nelson G	alea'i			Fal	afuafua	Lea'	ana	
12 shc h and 7 is m traum		19a. Informant's Name/Relationship (Robert D. Denchf	,		Mailing Address (Street 817 Adventi					
1 and 2 Health tem 27 l		20a. Method of Disposition	•	Place of D	isposition (Name of		Date_		ation - City or To	
Pages nent of nt: If I		1 ☐ Burial 2 次 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specil</i>	Removal from State		crematory or other place burg Cremat	, 1.00	ember 2009	Smi	thshura	, Maryland
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once.		21. Signature of Funeral Service Licer	nsee		22. Name and Addre				Funera.	
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ficate be executed to physician and sthe burial-transit of	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
ath certif aftending for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	tal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	Sy		23	3d. Date of delive Month	ery Day Year
s that gned b e deta	by Pr	Part II. Other significant conditions	contributing to death but not re	sulting in th	ne underlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to the	he cause of death?
law requires that the das been signed by the 2 should be detached							1 🗆 '	Yes 2	【No 3□ Prot	bably 4 Unknown
: The law i	Completed						24a. Was autoj perfo 1 ⊡Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of 2 No
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g Phy g Phy ter this neral d	— }	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Tin	ne of 28c. Injur	ry at	28d. Describe			<u>'y)</u>
endin eath. or: Aff	atio	1 Natural 5 Pending 2 Accident investigation	n			Yes 2 □No				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm cify)	, street, factory, office		28f. Location (City or To		Number or Rura	al Route Number,
he Hosp in 24 hou he Funel pletely fil	edical		nysician: To the best of my kinner: On the basis of examiand manner stated.							
To t with To t	Σ	29b. Signature and title of certifier	DMM), attending	1 phy	29c. Licens DOC	30020		11/	signed (Month,	
A		30. Name and address of person who John A. Shutta		em 23a) (Ty		ille, md	. 217	93		
Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	- A P					
HMH 17 Rev 1/20		DEC 0 5 2008	Denvin S.	190	Alexander					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 23 2009 9:00 a Olive Shadrick Ertter October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 44029 Flagstone Way California St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F Director 577-26-1207 88 01/08/1921 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than 'natural', or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at Director 1 ☐ Yes 2 XNo Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44029 Flagstone Way 20619 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status and 2 should be filed within 72 hours after or ealth and Mental Hygiene. n 27 Is marked other than "natural", or iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🛣 No þ Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1
Department of Health and Mental I
Important: if item 27 is marked of any injury or other traumair. ည John Hebb Shadrick Emma Berglund 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Ertter/Son 18385 Herring Creek Road, Tall Timbers, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 Donation 5 Dother (Spegal) St. George Episcopal 11/02/2009 Valley Lee, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature Funeral S Ldward N. brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed and burial-t Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical as the IF FEMALE nse If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an certificate has autopsy perform page 1 □Yes 2 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home SXXResidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 address of person who completed cause of death (Item 23a) (Type, Print) Jyoti Shah, M.D. 24035 Three Notch Road, Hollywood, MD Registrar's Signatur Year 3 2009 State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Susan B. Emmens 9 2009 4:50 A M Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8696 Wood Creek Parkway Wicomico Delmar 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2**XX**F Months Days Hours 495-16-8730 95 **Director** Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Michael Examinar must be notified at Director 1 X Yes 2 No MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene.

there than "natural", or items 23a or 8696 Wood Creek Parkway 21875 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2XXNo Specify þ Specify: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fil th and Mental F Clarence Gantt Josephine Swantner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 spartment of Health a portant: If item 27 Is / Injury or other train (Granddaughter) 8696 Wood Creek Parkway Heather Parsons Delmar, MD 21875 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department c Important: If any injury or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 11-11-2009 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Delmar, DE 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OVARIAN CANCER Physician MINTHS resulting in death) /Medical Due to (or as a consequence of). Examiner PERFORATED GASTRIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MINTHS Examiner July to for as a consequence off The law requires that the death certificate be executed burial-transit YEARS and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical HYPERTENCION YEARS as the the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∏No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 V Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 050929 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADARANG 32. Registrar's Signature S. DIVISIN ST. SAUSBURY 31. Date filed (Month, Day, Year) State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State of Mary State Registrar	land / Depa <i>Ce</i>	artment of He rtificate of De	alth and M e <i>ath</i>	lental Hyg F	giene Reg. No. 2009	38416
Dii-i-i		1. Decedent's Name (First, Middle, Last)		-		2. Date of Dea Month	th Day Year	3. Time of Death
Physicia /Medic		David Fr	eeman			Novemb	er 17, 2009	11:30 PM
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	cation of Death		4c. County of Death	
		St. Mary y Nursing Center 5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)	Leonardt	OWN Under 24 Hrs.	8. Date of Birtl	St. Mary'	S place (State or Foreign
Funeral Director		217 28 1762 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	_*		Hours Min.	(Month, Day	(Year) Cou	larvland
ъ		Usual Residence of Decedent						
arylar show	ž		c. City, Town or Lo					10d. Inside City Limits
he Mi	Director	Maryland Prince George	Cli	inton 10f. Zip Code			10g. Citizen of What Cou	1 □Yes 2 17 No
with 1		5800 Kirby Road		20735			United Sta	•
ms 23	Funeral	11 Marital Status 12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban,		ecify Yes or No-		can Indian,
al", or Ite	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced Armed Forces? 1 ☑ Yes, Give Year or Dates: ₩		_	Mexican, Puerto Specify:	Hican, etc.)	Black, White, Specify:	White
72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupation	on ing most of worki	na	16b. Kind of Business/In	dustry
within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Own e	DO NOT use retired)	ng most of works	ng	Conrete	
filed Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)		18	3. Mother's Name	(First, Middle,	Maiden Surname)	
uld be Menta arked atic ev	To B	Dewey Freeman			Mary	McNabb		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a Informant's Name/Relationship (Type Print) Dennis Freeman (Son)	1	ng Address (Street and Kirby Road			r, City or Town, State, Zij 20735	o Code)
ges 1 a		20a. Method of Disposition 2 ☐ Removal from State 2	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)		ate	20c. Location - City or To	own, State
t. Pag tment tant: njury		4 □ Donation 5 □ Other (Specify)	Cedar Hi	ill Cemeter	y Nov21	2009	Suitland, M	-
permi Depar Impor any ir		21. Signature of Funeral Service Ligensee Why. While hoo 13		2. Name and Address of Alexandria			Home,Inc 6 Inton, MD 2	633 01d 0735
		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	death. Do not en	ter the mode of dying,	such as cardiac o	or respiratory ar	rest,	Approximate Interval Between Opset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	Expira	long ta	lurs	>		days.
/Medical Examiner		Due to (or at a co	onsequence of):	2 Charle	ral P	Dalle	11	a Filly
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a co	ensequence of):	Town the state of	act 1)	rivou	12	muncy
cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	rain	- (and	282	_>		140
cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a co	ensequence of):	Otto				0
physi the b	dical	d						
eath certific attending p for use as	√Me	IF FEMALE: 23c. If yes, outcome of p.					23d. Date of deliv	erv
To the Hospital or Attending Physician: The law requires that the death certifulation after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	1		☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
signed b	y Pt	Part II. Other significant conditions contributing to death but no	ot resulting in the u	ınderlying cause given i	n Part I.	23e. Did to	bacco use contribute to t	he cause of death?
w require been sig should b		11 97	DA.			1 □ Y	es 2 No 3 Pro	bably 4 Unknown
e law re has be	Completed	Hyparlansian Dia	elete	S		24a. Was a	an 24b. Were auto	opsy findings available ompletion of cause of
The ate h	E O	AT .				perfor	med? death? 2 ■ No 1 □ Yes	•
clan: ertific ector,	Be (25. Was base referred to medical examiner?			6. Place of Death	(Check only or	ne)	
Physi this c	ဥ		2 ER/Outpatie				ence 6 Other (Speci	fy)
ending lath.	ation	27. Manner of Death 1 ▶ Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day, Ye	ar) 28b. Time o	Work?	s 2 □No	28d. Describe h	ow injury occurred	
tal or Att	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	reet, factory, office	1	28f. Location (S City or Tow	treet and Number or Run n, State)	al Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner stated.	amination and/or in	th occurred at the time, nvestigation, in my opin	date and place, ion, death occurr	and due to the o	cause(s) and manner as date and place, and due t	stated. o the cause(s)
To the within complete complet	M	29b. Signature and title of certifier	MI	29c. License no	6419		29d. Date signed (Month,	
BB 150/1	A	30. Name and address of person who completed cause of death James P. Jarboe, M.D. 24035		Print) tch Road, H	lo11ywoo	1, MD 2	20650	
Stat Registra		31. Date filed (Month, Day, Year) NOV 18 2009		and				
		Total Company	100	DA DE LA LA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D67788

29d. Date signed (Month, Day, Year)

11

2009

29c. License number

Hospital or Attending Physician: The law requires Be ည Certificate: within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu Medical

Division of Vital

IF FEMALE:

1 Natural

Accident

Suicide

4 Homicide

29a. Certifier

(Check

LEENA

Registrar

31. Date filed (Month, Day, Year) NOV - 5

RAO

29b. Signature and title of certifier

KODALI

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlotte Hall, MD

			1- State of Maryland / Dep	eartment of Health and I Pertificate of Death	, ,	ene _{9. No.} 2009 38418
			Decedent's Name (First, Middle, Last)	Timodic or Beating	2. Date of Death	3. Time of Death
	Physici /Medic		Frederick Nickolas Fischett	i	November	10, 2009 12:04 a M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
N. C.		-	37006 West Lakeland Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Mechanicsville o		St. Mary's
	Funeral Director		212-54-0712 XX M 2 F 61 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 10/26/1	9. Birthplace (State or Foreign Country) New York
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryl	tor		nanicsville		1 ☐ Yes 2x No
	th the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	ath wi		37006 West Lakeland Drive	20659		USA
36	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or items 23a or 28a-f show event, it "Modical Evarinar must be notified at	by Funeral	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give	Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	pecify Yes or No- Pican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-0036	2 hour		15. Decedent's Education 16a. Dec	edent's Usual Occupation	10	6b. Kind of Business/Industry
2	C 3 (D)	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worl DO NOT use retired)	king	,
2	filed within Hygiene. other than "	Cor	17. Father's Name (First, Middle, Last)	Electrician	(F) (A) () ()	IBEW Local 26
Maryland	thould be filed withir of Mental Hygiene. marked other than matic event, It also	To Be	Frederick John Fischetti	Mary	e (First, Middle, Ma	ergiadis
ary	should be f and Mental s marked o tumatic eve	F		ing Address (Street and Number or Ru		
	and 2 ealth a n 27 i		Melinda Feschetti/Spouse 370	06 West Lakeland I		chanicsville, MD 20659
altımore,	Pages 1 nent of H int: If iter iry or oth		LATRUMAL 2 LIGHTATION 3 LIBERTOVALITOR STATE 1	matory`or other place)		Oc. Location - City or Town, State
<u>=</u>	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) Queen of 21. Signature of Funeral Service Licensee			Helen, Maryland
Ra	Depz Depz Impo any i	4	Kyle S. Simons M01206	22955 Hollywood Rd	., Leonar	
Lag.	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac	or respiratory arres	st, Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	12.00	e.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	cuted nd ransit	Examiner	cause. Enter Underlying Cauce (Disease of Injury that initiated events			-
Ď,	certificate be executed ding physician and se as the burial-transit		resulting in death) Last Due to (or as a consequence of):			
08/PD	icate t	edical	d			
ROX	n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
	e law requires that the death certifichas been signed by the attending lie 2 should be detached for use as	Physician/M	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
S, T	es that igned l	by P	Part II. Other significant conditions contributing to death but not resulting in the t	ınderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
0	requir				1 🗆 Yes	2 No 3 Probably 4 Unknown
II Kecords,	The law requires that the rate has been signed by the page 2 should be detached.	Completed			24a. Was an autopsy performs 1 □ Yes 2	
VITal	certification rector,	Be	25. Was case referred to medical examiner? Hospital:	Other	h (Check only one)	
ō	Physer this eral di	2	1 Yes 2 No	111 3 DOA 4 D Nursing Ho	ome 527Residen	ce 6 Other (Specify)
0	inding ath. r: Afte ie fune	atio	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No	200, 2000, 100, 100,	mijary occurred
DIVISION	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	ie Hospit n 24 hour ie Funera	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month, Day, Year)
			· yvvv	H005575	> (11-11-09
ll	,			nants Lane, Leonar	dtown, MI	20650
1	Stat Registra		31. Date filed (Month, Day, Year) NOV 1 2, 2009 32. egistrar's Signatur	ale		

DHMH 17 Rev 1/2001

			1 - State of Maryland / De State of Maryland / De Registrar	partment of Health and Mental Hygiene ertificate of Death Reg. No. 2009 38419
	Physicia	an/	Decedent's Name (First, Middle, Last) Alice Ada Ford	2. Date of Death 3. Time of Death
	Medio Examir		4a. Facility Name (if not institution, give street and number)	November 10, 2009 11:30 A. M 4b. City, Town, or Location of Death
			5535 Gloucester Street	Churchton Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $1 \square M$ 2 \boxed{X} F 89 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Nonths Days Hours Min. 1
	d iow it	L	Usual Residence of Decedent 10a, State 10b, County 10c City Town or I	
	arylan ta-f sh ified a	Director	100. Oity, 10Wil Oil	ocation 10d. Inside City Limits Chton 1 □ Yes 2 🗓 No
	the M or 28	قَ	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	h with	Funeral	5535 Gloucester Street	20733 U.S.A.
.	or iten	by Fu	Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
93 93	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No Specify: Specify: white
5-	72 hou 1 "natu edica	Completed		edent's Usual Occupation a kind of work done during most of working 16b. Kind of Business Industry
75	vithin liene. er thar the M		Elementary/Seconday (0-12) College (1-4 or 5+)	secretary U.S. Government
Maryland 21215-0036	filed v al Hyg d othe) Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ŋ	of Hand 2 should be file of Health and Mental I fitem 27 is marked of rother traumatic eve	υ	Frank Unwin	Viola Byrnes
Ma	12 sho Uth and 27 is i	i		D Waverly Road, Owings, MD 20736
Baltimore,	of Heal of Heal fitem		20a. Method of Disposition 20b. Place of Disp	position (Name of Date 20c Location - City or Town State
<u><u><u>E</u></u></u>	Page 1 tment of 1 tant: If it		4 □ Donation 5 □ Other (Specify) Metropo	ematory or other place) Litan Crematory 11/12/2009 Alexandria, VA
Bal	permit. Page 1 Department of I Important: If it any injury or of once.		21. Sometime of Funeral Service Licensee	Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart falure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arrest, Approximate
F	hysician/		Immediate Cause (Final disease or condition Motastatic S	quamous Cell Carcinoma Interval Between Onset and Death Months
	Medical Examiner		resulting in death) Due to (or as a consequence of):	
		iner	Sequentially list conditions, If any, leading to in mediate oue to (or as a consequence of):	
	cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	
_	be exe sician a burial-	edical E	resulting in death) Last Due to (or as a consequence of):	
3/60	g phys as the		d	
Box 68	tendin r use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic oregnancy 23d. Date of delivery
8	Arranging Prystotan: The law requires that the death certificate be executed er death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M		Other (specify) Month Day Year
л Э	ned by e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
g.	equires en sig ould b	ted	Diabetes Mellitus	1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown
Vital Records,	has be	Completed		24a. Was an autopsy findings available prior to completion of cause of
ř	ificate or, pag		25. Was case referred to medical	performed? death? 1 Yes 2 No 1 Yes 2 No
VIII	nysicia lis cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)
DIVISION OF	Ing Pr		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	f 28c. Injury at work? 28d. Describe how injury occurred
SIOI	Attenor r death ctor: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st	M 1 ☐ Yes 2 ☐ No
	rai or y rs after al Dire ed in b		4 Homicide determined building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the propriat or Attending Priysican: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 \square Medical Examiner: On the basis of examination and/or inver	occured at the time, date and place, and due to the cause(s) and manner as stated. stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
,	vithin Vithin Comp		29b. Signature and title of certifier 7	death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)
				D26199 November 10, 2009
RN	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Emily A. Ulmer, M.D. 2000 Medical	Parkway, Suite 605, Annapolis, MD 21401
	State Registra	-	31. Date filed (Month, Day, Year) NOV 1 2 2009 Leneus J.	
-			THOU YOU THOU YOU	

Records, P.O. Box 68760, Division of Vital

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the within 2

> State Registrar

Medical

10800

and manner stated.

time ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day,

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09207 2009 38421 Roy Flannery State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 26, 2009 1928 hrs **Medical Examiner** Roy Lee Flannery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Min Director Country) Maryland 1 X M 48 August 13 217-80-2076 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No 23a or 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Maryland Frederick Walkersville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8396 Revelation Avenue 21793 uneral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Black Armed Forces White, etc. 1 Never Married 2 Married Yes 2 X No Specify: White 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet event, the Medical 21215-0036 Cook tment of Health and Mental Hygiene.

tant: If item 27 is marked other the 10 Restaurant/Hospitality 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Meredith Russell Flannery Catherine Lucille Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 7 7 1 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Catherine Heffner, mother 13707 Old National Pike, Apt A <u>, Mount Airy</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Department o
Important: 12/01/2009 Rockville, Maryland Bonation 5 Other Specify Parklawn Memorial Park 21. Sign were of Funeral Salvice Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland Approximate Interval 23a Fart I. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line **Physician** Between Onset and /Medical Death Carcinoma of lung Immedia Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiave Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and cal X UNPENDED AMENDED attending physician or use as the burial 23a,27, permE, g899 1/15/10 T T Physician/Medi Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 V No 3 Probably 4 Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page certificate ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one director, Be Division of Vital examiner? Hospital: 1 Othera Nursing Home 5 Residence 6 Other 2 CER/Outpatient 3 Inpatient DOA After this 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Pending 1 Yes 2 No Director: death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 4 Homicide 29a. Certifier 1

the Hospital or Attending Physician: To the F

> B. F. MARAN

State

Registra

November 27, 2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

O.C.M.E.

29c. License numbe

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner egistrar's Signature

and manner stated

31. Date filed (Month.

29b. Signature and title of certifier

Margarita Korell MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b per FH G898 12/2/09 dk

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 22, 2009 Milton Frazier Chester November 4:05 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 436 Cook St. Washington Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Yrs. Director 219-05-2678 June 16, 1914 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 436 Cook St. U.S.A. 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Maclicel Evaluation. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Maintenance <u>Manufacturing</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ν. Frazier Clarence Lutie Whissinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fannie E. Frazier / Wife 436 Cook St. Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Welty, 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/25/2009 Smithsburg Maryland Smithsburg Cemetery 21. Signaturo of Funeral Service Lignsee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Jh 9 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy rector, page 2 Cere 1 ☐Yes 2 ☐ No 1 ☐ Yes ≥ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Yes & No After this of funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation I Director: / 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours af To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29a, Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

W. E. Kut

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Regist

Hennsi

29c. License number

Avenue Hogerstow

29d. Date signed (Mopth, Day, Year)

2009

			Plea	ase Type or Pri				-	•	,
			For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of			giene Reg. No 2005	38423
	Dhysisi		Decedent's Name (First, Midd	lle, Last)				2. Date of De Month		3. Time of Death
-	Physicia /Medic	al	Judy Marie Gran			4. 0: 75	I C (Death	er 13, 2009	6:30 a M	
	Examin	er	4a. Facility Name (If not institution 5 Oak Street	n, give street and number,)	Indian	or Location of Death Head		4c. County of De	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthda)	-		8. Date of Bir (Month, Da	th 9. B	irthplace (State or Foreign Country)
	Director		218-38-8848 Usual Residence of Decedent	i i i i i i i i i i i i i i i i i i i	S8 Yrs.			Aug. 20	6, 1941 N	Maryland
	ırylanc show	ī	10a. State 10b. County		10c. City, Town or I		-			10d. Inside City Limits
	the Ma 28a-f	ecto	Maryland Cha	rles	India	1 Head			10g. Citizen of What (1 X Yes 2 No
	3a or	Funeral Director	5 Oak Street			206	540		U.S.A.	outiny:
	r deat	uner	11. Marital Status	12. Was Decedent Armed Forces	·	. Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jical Exwritter related at	þ	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 □Yes 2 No			Specify:	hite
2-0	72 hou	Completed	15. Deceder	nt's Education est grade completed)		edent's Usual Occu	pation during most of work	rina	16b. Kind of Busines	
121	within jiene.	duc	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire Clerk	nd)	<u>9</u>	Hotel	
d 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Ire Man	Be C	17. Father's Name (First, Middle,	, Last)	7000	- 010111	18. Mother's Nam	e (First, Middle	, Maiden Surname)	
ylar	ould be Menta arked	70	Aron Sidney Gri	mes			Effie	Mae Coo	oksey	
Maryland 21215-0036	id 2 sh Ith and 27 is rr traurr		19a. Informant's Name/Relations Patricia Hancoc				tand Number or Rui t, Indian		per, City or Town, State	, Zip Code)
re,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment reast be rediffied at once.		20a. Method of Disposition		20b. Place of Disp	position (Name of	Nov. 17	Date	20c. Location - City of	or Town, State
Baltimore,	Pages I tment of I tant: If ite		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ∐ Removal from State Specify)	Metropo	olitan Fur	Nov. 17 neral Serv	, 2009 vice	Alexandri	a, Virginia
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	Licensee		22. Name and Addr Williams		Home, P.	.A. an Head, Mo	
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that cause	M00668 d the death. Do not e	4270 Haw nter the mode of dy	thorne Rd ing, such as cardiac	or respiratory a	an Head, Mo arrest,	Approximate Interval Between
*	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Met	astatic	5 ma	Il Cell	Luna	y Cana	Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):			0		
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):					
	e be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
760,	te be e ysician e buria			d.	a consequence on.					
(687	The law requires that the death certificate bate has been signed by the attending physic bage 2 should be detached for use as the b	Physician/Medical	IF FEMALE:							
Вох	eath o attend for us	cian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnan	су		23d. Date of o Month	delivery Day Year
P.O.	it the d by the tached	hysi	1 □ Yes 2 XNo 9 □ Unknown	9 Unknown						
	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditi	ions contributing to death I	out not resulting in the	underlying cause gi	ven in Part I.		tobacco use contribute Yes 2 ☐ No 3	to the cause of death? Probably 4 □ Unknown
of Vital Records,	w requ	Completed						24a. Was		autopsy findings available
Re	The law	dmo						auto perfo	psy prior t ormed2 death 2 2 No 1 □ Y	o completion of cause of
/ita	ician: sertifica setor, p	BeC	25. Was case referred to medica examiner?				26. Place of Dea	1 ∐Yes th (Check only		55 2 1140
of	Physical this certain direction	은	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inj	ient 2 ER/Outpati	elit 3 DOA	her: 4 Nursing He		idence 6 Other (S	pecify)
ion	ath. r: Afte	atior	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, Di igation	ay, Year) Injury		rkí? ∐Yes 2∐No			
Division	or Attending Physician: after death. Director: After this certifica in by the funeral director, p	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	mined 28e. Place of In	jury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f. Location (City or To	(Street and Number or wn, State)	Rural Route Number,
	spital		29a. Certifier 1X Certifyi	ng Physician: To the best	of my knowledge, de	ath occurred at the	time, date and place	, and due to the	e cause(s) and manner	as stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2	I Examiner: On the basis and manner s	of examination and/or	investigation, in my	opinion, death occu	rred at the time	, date and place, and d	ue to the cause(s)
	vith voit	2	29b. Signature and title of certifie	er 1 - 1	A . 1	29c. Licen	se number	,	29d. Date signed (Mo	
7				mos tu	W(1)	1 1 7		r_	11/4-0/4 /	
	201-		30. Name and address of person	who completed cause of	death (Item 23a) (Type	e, Print)	1627		Voumber	16,2009
	BB 10			/ W.	aldors	e, Print)) 21	0603	Voumber	16,2009
	DB D Sta Registr		31. Date filed (Month, Day, Year,	/ W.	death (tem 23a) (Typo aran's Signature	e, Print)) 21		VTVIMber	16, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year М 6, Carolyn Guziak November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Angels Garden Assisted Living Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 218 F Months Days Hours Min. 95 Director 190-09-1745 08/27/1914 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, it is Medical Examinar must be notified at any once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5608 Lake Christopher Drive 20855 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 TXNo Specify. þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Rep. Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Valenty Koziol Catherine Porada ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald G. Guziak (Son) 5608 Lake Christopher Drive Rockville, MD. 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State November 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Josaphat Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Baldwin Borough, PA 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funera S rvice Lio nsee 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a į(C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner JV Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ Ne Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □ Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) A Stristed Other: 4 Nursing Home 5 Residence 6 Detner (Specify) tion: To 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death Funeral Director;

Baltimore, Maryland 21215-0036

Certificat Medical

ģ

6 Could not be determined

NOV 1 0 2009

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

within 2 10

Ata Molane, Mo	0063999	11-6-09
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	V
Ata Motamedi M.D., 17904 Georgia Avenue	, Suite 304, Olney, M	ID 20832
31. Date filed (Month, Day, Year) 32. Begistrar's Signature		

1 Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Senera

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Elaine Charlotte Goldstein 0615 M November 09, 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cente Montgone Brooke Grove Rehabilitation and Nursino sandu If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days 1 □ M 2 🕱 F 86 DC 578**-**20-8780 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🔀 No Montgomery Brookeville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20833 United States 19310 Adlerbarn Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🖔 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐Yes 21 No If Yes, Give Year or Dates: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Baefsky Joseph Oxenburg 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19310 Adlerbarn Court Brookeville, MD 20833 Jonathan Morrison/son in law Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grdns 11/10/2009 01ney, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc 21. Signature of Funeral Service Licensee Jamie Arthurs M01163 1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acute myocardial infarction minutes Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death

physician and the burial-transit be executed Box 68760. The law requires that the death certificate use as the attending p for use as P.0. the signed by the Division of Vital Records. certificate

Examiner Physician/Medical þ Completed Be the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this: Certification: To After this

Physician

/Medical

Examiner

Director

Funeral

ò

Completed

Be

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other trainment.

Physician /Medical

Examiner

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

up attending physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goce Brooke Hoffman, M.D. 18100 Stade School Road Sandy Spring, Haryland Zo &60 31. Date filed (Month, Da

D42046

Registrar

Medical

29b. Signature and title of certifier

		Please Type or Prir	it in Black In aryland / Dep				_		
	-	for State Registrar	Ce	rtificate of D	eath	Re	g. No. 2009	38426	
Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death	
/Medic	ai	John D. Gerlacher 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	ocation of Death	Novembe	r 8, 2009 4c. County of Deat	12:01 P ^M	
Examin	eı	Montgomery General Hospital		01ney			Montgome	erv	
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birt Year) Co	hplace (State or Foreign untry)	
Director		577-52-7051 Usual Residence of Decedent	73 Yrs.			03/21/1	936 Wasi	nington D.C.	
show d at	ř	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits 1 □ Yes 2 🛣 No	
28a-f rotifie	Director	Maryland Montgomery 10e. Street and Number	Brooke	ville 10f. Zip Code		10	og. Citizen of What Co		
st be		2908 Vandever Street		2083	3		United Sta	ites	
er mu	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
", or it	by Fi	1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:	No	1 □Yes 2⊠No	Specify:		Specify: Wh	nite	
natura ical E		15. Decedent's Education	16a. Dece	edent's Usual Occupa e kind of work done du	tion		6b. Kind of Business/		
ne. han "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	i+) life.	DO NOT use retired)			N . 1 . 0		
Hygie ther the	e Co	17. Father's Name (First, Middle, Last)	Repr	<u>esentative</u>		e (First, Middle, M	Nestle Cor	poration	
hental rked o	To B	Jack W. Gerlacher			Lillia	n B. Ett	er		
and Is ma		19a. Informant's Name/Relationship (Type. Print)					City or Town, State,		
Health sm 27 ther tr		Peggy Jeanne Gerlacher (Wit	20b. Place of Disp			Date 2	11e, Maryl		
Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Windows Examiner must be notified at once.		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Norbeck Mem. Park Norbeck Mem. Park							
portar portar Ce. jur		21. Signature of Funeral Service Licensee		22. Name and Address	1			ar y rana	
S m m g		The XI WIF						, MD. 20877	
		23a. Part 1. Enter the disease, or complications that caused shock, or beart failure. List only one cause on each lind Immediate Cause (Final	I the death. Do not er ne.	nter the mode of dying	ı, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
nysician Medical		disease or condition resulting in death)	a consequence of):					Minotes	
xaminer		Athen	lentic car	diovasular	discase			Years	
sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):						
n and ial-trar	Examiner	that initiated events C.	a consequence of):						
hysicia he bur	ical	d							
ding pl	sician/Medic	IF FEMALE: 23c. If yes, outcome	of pregnancy				20d Data of da	10	
atten I for us	ician		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	Day Year	
by the	Phys	9 ☐ Unknown							
signed I be de	by	Part II. Other significant conditions contributing to death b					acco use contribute to s 2 □ No 3 □ P	robably 4 Unknown	
been	ompleted	Dabeks				24a. Was ar		utopsy findings available	
te has age 2	ошо	Di model				autops	y prior to death?	completion of cause of	
ertifica ctor, p	Be C	25. Was case referred to medical examiner?				1 ☐ Yes 2 h (Check only one		S Z LINO	
this or al dire	၉	1 Ves 2 No Hospital: 1 Inpatie	ent 2 ER/Outpatie		4 LI Nursing Ho		nce 6 Other (Spe	ecify)	
th. : After : funer	tion	27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investigation 28a. Date of Inju (Month, Da		Work	es 2 □ No	28d. Describe ho	w injury occurred		
rector	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Inj	ury - At home, farm, si c. <i>(Specify)</i>	treet, factory, office		28f. Location (Sti	reet and Number or R . State)	ural Route Number,	
urs aft iral Di									
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best 2 ✓ Medical Examiner: On the basis of and manner street.	of examination and/or i						
vithin To th comp	Me	29b. Signature and title of certifier		29c. License	number	25	9d. Date signed (Mon	th, Day, Year)	
20	ļ	1 200			5 9770	1	Vovember i	08,2009	
		30. Name and address of person who completed cause of completed cause of complete cause of cause of cause ca			HO 2083	32			
Sta	te	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	1	1110 2000				
Registr	NOV & A COOL S								

		For State Registrar	State of Ma	aryiano	•	rtificate of			Reg. No. 2	009	3842
Physicia	an	1. Decedent's Name (First, Middle, I						2. Date of De Month	Day	Year	3. Time of Death 12:15 PM
/Medic		Wayne Ha 4a. Facility Name (If not institution, g	rrison Glad	u		4b. City, Town, o	r Location of Dea	Novemb ath	1	2009 nty of Death	12.131
Examili	-1	39115 Deborah C	Court				0659				Mary's
Funeral Director		5. Social Security Number 213-38-1716	. Sex 7. Age 1	e (In yrs. la 66	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month, Da	av, Year)	Coui	place (State or Foreign ntry) ct of Columb:
		Usual Residence of Decedent						December	10, 194.		
arylan show	ž	10a. State 10b. County	Manula	10c. City,	Town or Lo		echanics	evilla		1	1 ☐ Yes 2 ☑ No
the Ma	recto	Maryland St 10e. Street and Number	. Mary's			10f. Zip Code	echanics	PATITE	10g. Citizen	of What Cour	
3a or	Funeral Director	39115 Deborah C	Court				0659			USA	
r death	uner	11. Marital Status	12. Was Decedent B Armed Forces?		. 13. \	Vas Decedent of F f Yes, specify Cub	lispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	o- 14. F	Race - Americ	can Indian, etc.
be filed within 72 hours after death with the Maryland trial Hygiene. tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examir or must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 √ Yes 2 □ N If Yes, Give Year or Dates:	No		∐Yes 2k∏No	Specify:			ecify: W	Mite
2 hou natura	ted	15. Decedent's (Specify only highest of	Education		16a. Deced	ient's Usual Occup kind of work done	oation	arkina	16b. Kind o	f Business/In	dustry
rithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	j+)	life. L	outer Spe	d) _	OIKHIG	Govern		
filed w Hygie ther t		17. Father's Name (First, Middle, La	st)		Comp	deer bye		ame (First, Middle			Columbia
Aental Aental rked o	To Be	Leonard Gladu					Mai	ry Kirch	ner		
12 should be filed within 72 hours and Mental Hygiene. 7 is marked other than "natuu traumatic event, the Medical		19a. Informant's Name/Relationship			19b. Mailin	g Address (Street	and Number or I	Rural Route Numb	per, City or To	wn, State, Zij	Code) Box 144
- C - N -		Allen L. Gladu /	Brother	20h Pla		McKay's		ane Val.		on - City or To	
Pages nent of int: If ite		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				sition (Name of natory or other place in Cremator	37	ember 6,		iria, Vi	
in program		21. Signature of Funeral Service Lic			22	. Name and Addre	ess of Facility	Funeral H	Iomo P A		
permi Depar Impor any ir		Michael	Hardin	er)_		P.O. Box	y-Gardiner 270 Leona	rdtown, M	20650		
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused ly one cause in each lir	the death. ne.			-				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	200Deague		erotre	(and	Co VA	scul	an d	estice
Examiner			bue to (or as	a conseque	stice oi).						
pa tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (cr as	а попведне	ence of):						
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tificate be executed by physician and as the burial-transit	edical E		d								
a g ≡ C		IF FEMALE:									-
The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	hysician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Fetal	death 3□	Ectopic pregnanc	ру		23d.	Date of deliv Month	very Day Year
at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	it time of ge	ain 5L	Other (specify) _					
res that signed b	by Pł	Part II. Other significant conditions	s contributing to death be	ut not resul	ting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use c	ontribute to t	the cause of death?
w require been signature								_ 1 🗆	Yes 2 N	o 3 🗆 Pro	bably 4 💢 Unknown
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		25. Was case referred to medical					00 81	1 □Yes	2 No	1 ☐ Yes	2 □No
Attending Physician: The release. Attending Physician: The release. Setor: After this certificate by the funeral director, page.	To Be	examiner?	Hospital:	ent 2 🗆 E	R/Outpatier	nt 3 DOA Oth	ner:	eath <i>(Check only</i> Home 5 💢 Res		Other (Spec	ify)
Fig. 19		27. Manner of Death 1 ▼ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ıry :	28b. Time of Injury	Woi		28d. Describe	how injury oc	curred	
ttendi death. ttor: A	icati	2 Accident investigat 3 Suicide 6 Could not	t be 280 Place of Init	un - At bon	ne farm str	M 1 = eet, factory, office]Yes 2□No	28f Location	(Street and N	umber or Pu	ral Route Number,
i gift o	Certification:	4 ☐ Homicide determine	building, etc	c. (Specify))	cot, lactory, office		City or To	wn, State)	miber of Hur	ai rioute riumbei,
urs ile			Physician: To the best caminer: On the basis o								
To the Hosp within 24 ho To the Fune completely f	Medical	one)	and manner sta	ated.				Journey at the time			
vit Vo Cor	<	29b. Signature and title of certifier	A. A.	A. A		29c. Licen:	7428			gned (Month, -3	
	1	30. Name and address of person when the state of the stat	no complete cause of d	leath (Item	23a) (Type,	100	, ,		11	30	

State Registrar

William D. Boyd, II, M.D.

31. Date filed (Month, Day, Year)

25365 Pt. Lookout Road

32 Registrar's Signature

Leonardtown, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 11 Physician/ Year Day () Jean Wolfe Gray 1917 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Davs Hours Min Country) Kentucky (M97th Day Year) 671971920 Director 404-18-4926 89 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No St. Mary's Maryland California 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 23103 Piney Wood Circle 20619 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ .. Page 1 and 2 should be f tment of Health and Menta tant: If item 27 is marked jury or other traumatic en Wolfe Helen Locke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Anne Knoefel/Daughter 23103 Piney Wood Cr., Claifornia, MD 20619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State permit. Page Department (4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial 11/12/2009 Louisville, Kentucky Signature Funeral Service Linnsee
Edward M. Bernsfiled, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumoma Medical Due to (or as a consequence of): Examiner O bistunction mal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hyperical calin or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death Was decedent pregnant 23d. Date of dewerv 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year 2 \square No 9 Unknown 9 🗒 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has I performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1. Natural iniurv work? 1 Yes 2 No ☐ Accident Investigation after death Director: / 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 24 hours at Funeral D Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D60888 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakhi Krishnan, M.D. 26840 Point Lookout Rd., Leonardtown, MD 20650

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 12

			1 - For State Registrar	State of Marylar		rtificate of		Re	eg. No. 2009	
h	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h /10/2009 ^{Year}	3. Time of Death 4:00 pm
1	/Medic		Albert Gabbay 4a. Facility Name (If not institution, give	street and number		Ab City Town o	r Location of Death	11/	4c. County of Deat	
	Examin	er	Genesis Nursing	,			ldorf		Charles	
- :	Funeral	10	5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	if Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
þ	Director		230-78-6617	⁸ M ^{2□ F} 83	Yrs.	Months Days	Hours Min.	8. Date of Birth	1926	Morocco
	pu »		Usual Residence of Decedent 10a, State 10b, County	10c Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	a-f sho	ctor	MD Charle		Waldo					1 ☐ Yes 2 ☑ No
	th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	23a ust b		4140 Old Washingt	on Road		2060			U.S.A.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛛 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
9	72 hou natura ical E	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Occup	ation	ina	16b. Kind of Business/	Industry
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7	ed wi	Con	12		Camer	a Repair	Technicia		Industrial	Camera Co
gug	be fill ad oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, 1 1known	Maiden Surname)	
Z	nould be d Mental narked o	ဥ	unknown 19a. Informant's Name/Relationship (Ty	ma Drintl	40h Maili	Add (044			; City or Town, State, 2	7:- 0 - 1-1
Mai	d 2 sho th and 7 Is ma trauma		` ` `							zip Code)
	tem 27 other tra		Michelle Della-Ca 20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of	1		20c. Location - City or	Town, State
Baltimore,	Pages tment of the tant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Geo	orge Wa		Cem 11/12		Adelphi, M	
Bai	permit. Departm Importa any Inju		21. Signatur F neral Service Licens	ee /					Home Calvings, MD 2	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the deat ne cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ARTERIOSCLE	PUTIC	CHERRE	VASCULAR.	0156	ASF	Onset and Death
r	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	pri-pro-		1-10-1		
9	Step31	-	Sequentially list conditions if any, leading to immediate	b. Due to (or as a consec	ruence of):					
	rted nsit	nine	Cause (Disease or injury	200 10 (0) 40 4 0011000	quenos on).					
Ć.	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):	<u> </u>				
68760,	ificate be executed physician and as the burial-transit	edical		d						
_	- D 6		IF FEMALE:							
Вох	eath certifi attending for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn 1□Live birth 2□Feta	al death 3[☐Ectopic pregnanc	<i>y</i>		23d. Date of del Month	ivery Day Year
о <u>.</u>	that the dealed by the are detached for	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	death 5[Other (specify) _			Month	Day Tour
<u>α</u>	that the ed by detact		Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
or Vital Records,	The law requires that the death cert te has been signed by the attendin age 2 should be detached for use a	ed by						1 □ Y€	es 2∐No 3∐Pr	obably 4 Unknown
900	has bee	Completed						24a. Was a	n 24b. Were au	utopsy findings available completion of cause of
œ —	The ate ha	mo:						perforr	med? death? 2. No 1 ☐ Yes	
/ita	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?			T	26. Place of Deat	h (Check only on	e)	
or .	Physician: r this certifica ral director, I	2	To res Za No	Hospital: 1 Inpatient 2			4 M Nursing Ho		ence 6 Other (Spe	cify)
	ding F	ertification:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe no	ow injury occurred	
Division	or Attending after death. Director: After in by the fune	ficat	3 Suicide 6 Could not be	28e. Place of injury - At h	lome, farm, st			28f. Location (St	reet and Number or Ri	ural Route Number.
S S	al or / after I Dire	erti	4 Homicide	building, etc. (Speci	ify)			City or Towr	n, State)	
	To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deal ation and/or in	th occurred at the tinvestigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Ment	h, Day, Year)
			1/1	10		1)/	2916		11/11/1	9
١٨			30. Name and address of person who c	ompleted cause of death (Iter	m 23a) (Type,	Print)	10	1	11111	(
ak	v J		Louis Kaufman,	ALAREA .		e Center,	Suite 20	7, Wald	orf, MD 200	502
	Sta Registr	_	31. Date filed (Month, Day, Year)	2 2009 Lune		back	,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 38430 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death NOV. Day **Physician** 2009 9 NORA M. GREEVE 10:30A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SUNRISE SENIOR LIVING CENTER MONTGOMERY VILLAGE MONTGOMERY Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min 1 □ M 2 🗹 F Director 85 FEB 29 1924 BELGIUM 175-24-7757 Usual Residence of Deceden the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show soical Examiner must be notified at 1 Yes 2 □ No Director MONTGOMERY MONTGOMERY VILLAGE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 19319 CLUB HOUSE ROAD 20886 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene, and them 27 is marked other than "natural", or items 23 ary or other traumatic event, the "Medical Examinal musty or other traumatic event, the "Medical Examinal must 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRANSLATOR SECRETARY FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARIA MERCKX HERMAN GREEVE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH ST.OURS/DAUGHTER 21010 CLARKSBURG ROAD, BOYDS, MD 20841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department of Important: If it any Injury or c 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State STAUFFER CREMATORY 11/12/09 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Physician months RECTAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiclan for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 V No 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director. I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PNo 1∏ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manyer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4

DHMH 17 Rev 1/2001

State Registrar GEORGIA

30. Name an dress of person who completed cause of death (Item 23a) (Type, Print)

MD

18121

32. Registrer's Signature

DAPHNA HENKIN,

31. Date filed (Month, Day, Year)

D53528

AVE., #103, OLNEY,

NOVEMBER 10, 2009

MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo 38431 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month John A^{M} G. Gowin November 2009 4:45 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Country Meadows Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 € M 2 🗆 F Months Days Hours Min. 126-07**-**8911 90 Jan.28,1919 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Frederick Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2913 Green Hill Court 21754 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify 3 X Widowed 4 ☐ Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Personnel Worker Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myron N. Gowin Grace Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John Gowin/ Son</u> 2913 Green Hill Court, Ijamsville, MD 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 11/9/2009 22. Name and Address of Facility Brentwood, Maryland 21. Signature of uneral Ser Stauffer Funeral Homes P. A. 621 Opossumtown Pike, Frederick, Maryland21702 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WPP/4 Dreumania Due to (or as a onsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery eath 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

10a. State

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Examinar rough by notified at once.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Completed by Be

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signat

4 Homicide

(Check only one)

Certification: To

attending physician and for use as the burial-tran-After this certificate has been signed by the funeral director, page 2 should be detached within 24 hours after death

To the Funeral Director: .

completely filled in by the f

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	To the within 2	
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State Registrar

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de
	4 ☐ Pregnant at time of dea 9 ☐ Unknown

pertension

5 ☐ Pending investigation

6 Could not be

determined

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

1 Yes

1 ☐ Yes 2 No

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Souther (Specify) Retirement

Other: 4 Nursing Home 5 Residence 6 Souther (Specify) Retirement

Other: 4 Nursing Home 5 Residence 6 Souther (Specify) Retirement 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. title of certifier

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Momas

32. Registrar Signature 2009▶ NOV

ohnson Dr. Frederick MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year O Physician 12:35 IM Dorene Elizabeth Gidden Ĺ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** oastal salisbur Hospice WICOMICO at If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) ocial Security Numbe 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, March 29 1 □ M 2 💢 F Months Days Hours 81 Maryland 213-24-0954 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 K No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8050 Levin Dashiell Road 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify \$ Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Price Carrie West မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7662 Fentral Avenue - Salisbury, MD 21801 Anthony Giddens/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory Gardens 11/14/2009 4 ☐ Donation 5 ☐ Other (Specify) Hebron, Maryland 21. Sig your of Funeral Service Licen 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one sause on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final HRIMPER DISRASR resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cleaner India) that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2/ETNo 1 □Yes 3 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only o) Hospital: Other: 4 Nursing Home 5 Residence of Other (Specify) HOSPI CR 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 9. Division of Vital Records,

Funeral

Director

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Evanther must be notified at

Important: If item 27 is any injury or other tra

Department of

Physician

Examiner

/Medical

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

Box 68760

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State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d, Date signed (Month, Day, Year)

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and manner stated.

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you

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nov 20, 2009 **Physician** 5:05pm^M Gillis Edwin Η. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Lonaconing Eale Nursing Home Date of Birth (Month, Day, Year) Dec 14, 1931 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ ¥ 2 □ F 235-48-4709 77 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evolviand. 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 □ No Mt. Savage MD Allegany Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21545 USA P.O. Box 364 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Baltimore, Maryland 21215-0036 Specify: Specify. δ white 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) High School Art Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vivian Thompson Gillis Edwin H. Gillis, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 20315 Morgan St., SW Frostburg MD 19a. Informant's Name/Relationship (Type. Print)
Vivian Ann Frost MD 21532 daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/2009 MD Sunset Memorial Park Cumberland 4 ☐ Donation 3 ☐ Other (Specify) 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or c indition resulting in 1 th) USCULAR ACCIDENT EREBRO **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the l as use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day for 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t , page 2 s autopsy performed? 1 Yes 2 No 1 ☐Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗖 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Thomicide

filled in by the completely

State Registrar

Medical

29a. Certifier

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALSH RD CUMBERLAND 925 M.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 38434 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sovembe 7:29 PM Robert Μ. Gaines 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death <u>Doctors Community Hospital</u> Georges <u>Lanham</u> Prince Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Hours Min. (Month, Day, Year) 108-34-3409 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No PG Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12607 Prestwick Drive 20744 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 🛭 Married Yes, Give 2 🗌 No 1963 1967 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical IBM Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank R. Gaines Jr Albertha Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2607 Prestwick Drive ort Washington, Md. Carol Anne Gaines/wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Removal from State 1/20/09 Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Poughkeepsie, NY 21. Signatur, of Funeral Service Licensee F.H. ,Md.20746 Hodges & Edwards Suitland Hill Rd., Silver 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease or condition resulting in death) yocardia Due to (as a consequence of) unknown

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at

Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

Be Completed by Physician/Medical

Certificate: To

Medical 298

Disease oronar Due to (or as a consequence of Due to (or as a consequence of):

Baltimore, Maryland

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran-After this certificate has within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or

23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
contributing to death but not resulting in t	the underlying cause given in Par

3 ☐ Ectopic pregnancy		23d. Date of de	elivery
5 ☐ Other (specify)		Month	Da
he underlying cause given in Part I.	23e. Did tobacco	use contribute to	o the c

29d. Date signed (Month, Day, Year)

November 12, 2009

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 5 Other (specify)	Month Day Year
Part II. Other significant conditions of		bacco use contribute to the cause of death?
	24a. Was a autop. perfor 1 □ Yes	sy prior to completion of cause of
25. Was case referred to medical	26. Place of Death (Check only one)	-
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 Fr/Outpatient 3 DOA Other: 4 Nursing Home 5 Reside	ence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio	n (Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	w injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		reet and Number or Rural Route Number, ,, State)

		A			
(Check	2 Medical Examiner:	n: To the best of my knowledge, death occur On the basis of examination and/or investigation ractioner: To the best of my knowledge, death	n, in my opinion, death occurred a	t the time, date	and place, and due to the cause(s) and manner stated
29b. Signature ar	nd title of certifier		29c. License number		29d. Date signed (Month. Day, Year)

			1).	X	- /	41)		
20	Nomo an	d address of n	ereon who co	mpialo	d cause	of death	(Itam 22a) (Type	Drint)

Good Luck, Rd Lapham md 20706 31. Date filed (Month, Day, Year) 2. Registrar's Signature

00061637

State Registrar

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within 2 To the I

09-08694

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Ellsworth		State of Maryland / Department o 1- For State Certificate o		
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	Death	Reg. No. 2 0 2 0 1 2. Date of Death 3. Frime of Death 3
Medical Exami		Robert E. Haupt		November 8, 2009 Year 1757 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
*		8 West Green Street	Midddletown	Frederick
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Foreign
Director	ļ	$219-14-8659$ $1 \times M$ 2 F 85		9/15/1924 Country) MD
any	- }	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	tion	10d. Inside City Limits
*			dletown	1 X Yes 2 No
te Maryland or 28a-f show fied at once.	g	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho	Director	8 W. Green St.	21769	USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.			as Decedent of Hispanic Origin? (Sp	ecify Yes or No- 14. Race - American Indian, Black,
leath item	Funeral	1 Never Married 2 Married Armed Forces? If X Yes 2 No	es, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
after c	by F	3 X Widowed 4 Divorced of Pales: 0 Pales: 1943-19461	Yes 2 X No specify:	Specify: White
natur	8	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	nt's Usual Occupation (Give kind of w nost of working life. DO NOT use reti	red)
16 n 72 l nan ", ical E	ig et	Elementary/Secondary (0-12) College (1-4 or 5+)	eman	road building co.
withi withi giene.	Completed	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
filed at Hyg	BeC	Henry Haupt		Lighter
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To B			Rural Route Number, City or Town, State, Zip Code)
MD id 2 sho lith and m 27 is aumati	Πĵ	Robin Haupt (Son) 1254	4 Wolfsville F	Rd., Myersville, MD21773 Date 20c. Location - City or Town, State
e, l l and Health item			sition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State Luthera 4 Dogation 5 Other Specify:	n cemetery 11	./12/2009Middletown, MD
altir mit. F partme porta				
	4	V role (P	OB 18, Middlet	oson Funeral Home cown, MD 21769
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart Approximate Interva Between Onset and
/Medical vaminer		Immediate Cause (Final disease a. Contact Shotgun Wound of Chest		Death
		or condition resulting in death) Due to (or as a consequence of):		
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	min	cause. Enter Underlying Cause (Disease or injury that initiated		
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):		
O, e be executed ysician and burial - transit	dical	UNPENDED AMENDED		
50, te be e ysicia buria				23d. Date of delivery
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	ian/M	23h Was decedent pregnant in the	etal death 3 Ectopic pregna	
ox 6 th cer trendi	sicia	4 Pregnant at time of death 5	Other (Specify)	
Box he death c the atten hed for us	Physici	9 Olikilowii	and advise a source since in Boot I	23e. Did tobacco use contribute to the cause of death?
ires that the signed by I be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Fart i.	1 Yes 2 ✓ No 3 Probably 4 Unknown
S, I				24a. Was an 24b. Were autopsy findings available
Cords, law requir has been s	be			autopsy prior to completion of cause of performed?
Rec The I cate I	Completed			1 Yes 2 No 1 Yes 2 No
Division of Vital Records, rate dear Astending Physician: The law requir and referent. As all Directors. After this certificate has been seled in by the funeral director, page 2 should I	Be (25. Was case referred to medical examiner? Hospital: 4 Inpution: 2 FR/Outputies	26.Place of Death (Check	
F Vil Physic r this	ဥ	1 Yes 2 No Inpatient 2 ER/Outpatien	IL O DEA TURISH	ng Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred
n of ding Ph	ē	27. Manner of Death 1 Natural 5 Pending PoUND: 28a. Date of Injury FOUND: 28b. Time of FOUND: FOUND: FOUND: FOUND: Pound Poun	Injury 28c. Injury at Work?	Subject shot self
Sio Atten deatl ector: by the	cati	Accident Investigation Nov 8, 2009 1730 hrs 28e. Place of Injury - At home, farm, str		28f. Location (Street and Number or Rural Route Number, City
Divi al or s after al Dir	Certification:	Suicide 6 Could not be determined (Specify) regidence	eer, ractory, office building, etc.	or Town, State) 8 West Green Street, Middletown, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 4 Cartifician Physician To the best of my knowledge death ass	urred at the time, date and place, and	
the II hin 24 the F	ica	one) 2 Medical Examiner: On the basis of examination and/or investig		
To To	Medical	and manner stated. 29p Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		P 10 - PROD 1	O.C.M.E.	November 9, 2009
		30. Name and address of person who completed cause of death (Item 23a)		
10+1		Patricia Arpnica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimo	re, MD 21201
	tate	31. Date filed (Month) (%) (%) 2 2009 32. Redistrar's Signature	backer	
Regis	trar	p. M		

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			For State Registrar	State of Ma	aryland	/ Depa	artment of H	lealth and I Death		giene Reg. No.	2009	38438)
	Divinisi		1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of Death	
	Physici /Medic		Alice Ada Hershma	n					Novemb	er 18	3, 2009	8:10 A M	
	Examir		4a. Facility Name (If not institution, give				4b. City, Town, or		1	4c. (County of Death		
			Garrett County Me				Oaklar If Under 1 Year		Data of Dist		Garrett	place (Otate as Fauring	_
L	Funeral Director		220-38-0833	M 2 TOTE	e (In yrs. las	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da April	y, Year)	Cou	place (State or Foreign intry) cyland	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	-
	Mary f sh	to	MD Garret	t	0ak	1and						M∏Yes 2 ☐ No	
	72 hours after death with the Maryland 'natural', or liems 23a or 28a-f show dical Examiner must be notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	ntry?	
	th wit		218 Weber Road				21550			Un	ited Sta	ites	
	ems er.m	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ∐Yes 2 N	er in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 1	4. Race - Ameri Black, White,		
36	or it	by Fi	1 Never Married 2 Married	If Yes, Give	lo	1	1 □Yes 2X No				Specify:		
0	hour tural	pa p	3 N Widowed 4 □ Divorced 15. Decedent's Educ	Ye ar or Dates:		16a Dece	dent's Usual Occupa	ation	I	16b Kin	What of Business/Ir	nite	_
15	n "na	Completed	(Specify only highest grade	e completed)		(Give	kind of work done of DO NOT use retired	furing most of wor	king	TOD. TOT	id of Business/ii	iddotty	
212	with jiene r thau	E	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Hom	emaker			Owi	n Home		
þ	al Hyg othe	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle,	Maiden 5	Surname)		
/lar	uld be Ments Irked Itic ev	인	Bert Ream					Eva Ell	is				
ar)	and I and I is ma	. 19	19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Mailir	ng Address (Street a	and Number or Ru	ıral Route Numbe	er, City or	Town, State, Zi	p Code)	
Σ,	and 2 ealth n 27 her tr		Craig Hershman, S	on			Box 2426						
ore	Jes 1 t of H if iter		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ F	emoval from State	20b. Pla	ce of Dispo netery, crer	sition (Name of matory or other plac	θ)	Date	20c. Loc	cation - City or T	own, State	
Ë	t. Pag tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)		Terr		a Cemeter		21/2009		ra Alta,		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: in item 23a or 28a-f show amortant: In item 23a or 28a-f show injury or other traumatic event, the Medical Expriner must be notified at once.		21. Signature of Funeral Service License	wither		22	2. Name and Addres David A. 21 N. Se	ss of Facility Burdock cond St.	Funera , Oaklar	1 Horad, M	ne, P.A. D'21550		
п			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each lin	the death. ie.	Do not ent	er the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between	
4	Physician	Ϊ́	Immediate Cause (Final disease or condition	Diasto	lic C	onges	tive Hear	t Failur	:e			Onset and Death	
4	/Medical Examiner		resulting in death)	Due to (or as a	a conseque	nce of):							
	Lxammer	_	Sequentially list conditions,),									_
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	ence ot):					d		
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):							-
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687	ificate g phy. is the	edic		l									
Box	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			Te.02			2	3d. Date of deliv	very	
B.	deatl e atte	icia	in the past 12 months? 1 ☐ Yes 2 🕅 No	1 Live birth 4 Pregnant at			☐ Ectopic pregnancy ☐ Other <i>(specify)</i>	·			Month	Day Year	
P.0	at the de by the tached	hys	9 🗆 Unknown	9 🗌 Unknown									_
S,	es tha igned be det	by F	Part II. Other significant conditions cor	-	ut not result	ing in the u	nderlying cause give	en in Part I.		_	_	the cause of death?	
of Vital Records,	w require been si should t	bed	Acute Renal Fai	lure					1 🗆)	res 2. ☑	No 3 □ Pro	bably 4 Unknown	
ec	e law r has be	Completed	Dementia						24a. Was	SV	24b. Were aut	opsy findings available ompletion of cause of	
= H		5	COPD						perfo 1 □ Yes	rmed? 2X☐No	death?	2 □No	
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?				To:		ith (Check only o	ne)			_
of	this aldir	၉	I Tes 2 2 100			R/Outpatier	nt 3 DOA Othe	4 Li Nursing F	lome 5 ☐ Resid			ify)	_
ion	nding ath. r: After e funer	ation	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		Injury	Work	yat :? Yes 2 □No	28d. Describe I	now injury	occurred		
Division	al or Attendii s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	iry - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (8 City or Tov	Street and vn, State)	d Number or Flui	ral Route Number,	
	To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physical Examl	sician: To the best oner: On the basis of and manner sta	examination	ledge, deat on and/or in	h occurred at the tir evestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the	Me	29b. Signature and title of certifier	7			29c. Licenso	number A	4	29d. Date	e signed (Month	, Day, Year)	
			30. Name and address of person who co	empleted cause of d	eath /ltc	Oa) /Time	Print)	(A)	1	Nove	ember 19), 2009	_
		5	Paul Daniel Mill	*			Acres Dri	ive, Oakl	land, MD	215	50		

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5:40 AM ARI vel Hagens 09 /Medical 4b. City 4c. County of Death 4a. Facility Name (If not institution, give street and humber) Town, or Location of Death Examiner Charles Year If Under 8. Date of Birth (Month, Day, Year) 5/31/1941 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday, Funeral 1 □ M 2 🗗 F Months Days Hours Min. 68 Director 213-42-7550 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extra vilval must be mailthed at 1 Yes 2 No Director Waldorf Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 10385 Chamberlin Ct. East 20601 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify Black If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government 12 Computer Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary I. Hagens ဥ William S. Dent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10385 Chamberlin Ct.East, Waldorf MD 20601 Lenora Hagens/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Peters Ch 11/13/09 Waldorf Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA, Aquasco MD 20608 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, aftending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown been si should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? Yes 2. No certificate | 1 □Yes 1 ☐Yes 2 ☐ No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending neral Director: A 1 □Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) O

State Registrar Robert

31. Date filed (Month. Day. Year)

DHMH 17 Rev 1/2001

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32. Revistrar s Signature

Center Suite 302

Waldurf

20604

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12070

Ace

Amend] 09-08880 Rita Carrier Hadi		em # 4a. Ceci r Phy Please Ty	pe or Print tate of Mary	1/19/2(in Black In	009 riv idelible in	k. Ensu Health a	ure	All Co Menta	pies	Are Leg	jible.		
rata Carrior Flag.		I- For State	tate of Mary		rtificate of			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, =		g. No.	20	09 386
Physicia Medical Exami	an/	1. Decedent's Name (First, Midd Rita Carrier			31					Date of Deat Month November	h	Year)9	3. Time of Death 1613 hrs
		4a. Facility Name (if not institution	on, give street and i	number)		b. City, Town, Elkton	or Lo	ocation of D		r		ounty of Deat	h
Eurosal		Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Y	/ear	If Under 2	24Hrs.	8. Date of Bir		/YYYY) 9. Bi	rthplace (State or
Funeral Director	- 1	230-62-4061	1 M 2X F	3 ()	63 yrs.	Months D	ays	Hours	Min.	05/25	/1946	Forei	^{ountry} Virginia
		Usual Residence of Decedent		Jana City	Tour as Lagati								10d. Inside City Limits
ow any		10a. State 10b. County Maryland Cec			, Town or Location E1kton	OI I							1 Yes 2 X No
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D 21 should and Me	1°	19a. Informant's Name/Relation											te, Zip Code)
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Physician /Medical caminer		failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on each line. se a. Atherosc	lerotic Cardio	vascular Dis								Between Onset and Death
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O IVA		30. Name and address of pers	brassel /	cause of death (Ite	em 23a)).C.N				Nove	ember 16,	2009
124		Melissa Brassell, MI	O Assistant I	Medical Exam	iner 111 l	Penn Stree	et, B	altimore	, MD	21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38439 Amended Item 10c, 11/12/09.per F.H. Certificate of Death D_H_WCHD . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIAM J. HENRY Month Medical 10 November 2009 6:40 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BERLIN NURSING HOME WORCESTER BERLIN 5. Social Security Number . Sex 1 ី M 2 🗀 F If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 196-12-6661 Director 85 5(Mogth, Pay Year) PENNSYLVANIA Usual Residence of Decedent 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits DELAWARE SUSSEX 319 HOLLY STREET Millsboro 1 K Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 HOLLY STREET Funeral 19966 US "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 IX Yes 2 □ No
If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 X Married Black, White etc. Baltimove, Waryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) BRAKEMAN RAILROAD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည AMBROSE W. HENRY MAUD T. LIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, WILLIAM J. HENRY / SON 50 NORTH 9TH ST., APT. 301, READING, PA. 19601 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11-18-2009 MILLSBORO, DELAWARE 4 Oonation ther (Specify) 21. Signati re of Funer Address of Facility
FUNERAL
TCHER ST. FRANKFORD, , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure List only one cause on each line Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Dul to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to (or as a soll sequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 Yes 2 9 Unknown Day Year After this certificate has been signed by the funeral director, page 2 should be detached g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA After this Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work?
1 Yes 2 No 24 hours after death. Accident Investigation 3 Suicide 4 Homicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 e and title of certife 11/10/08 and address of person who completed cause of death (Item 23a) (Type, Print) Dard 11816 an intrad DH 6+1 31. Date filed (Month, Day, Year)

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Alan S. Kaplan, MD, 8901 Wisconsin Avenue, Bethesda, Maryland

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200^{rear} James Elmer Hooper, Jr. November 10:15a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Shores Lexington Park St. Mary's 8. Date of Birth (Month, Day, Year) 10/23/1933 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral XXM 2 F Months Days Hours Director 220-28-5522 76 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinat and Director 1 ☐Yes 21 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21768 Mayfair Lane 20653 filed within 72 hours after death of Hygiene. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🖾 No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Salesman Shoe Store s 1 and 2 should be fil. Thealth and Mental H tem 27 is marked منه 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Ε. Hooper, Sr. Elva Μ. Garrison ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Pryor/Sister 21981 Spring Valley Dr., Lexington Park, MD 20653 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/6/2009 Brinsfield-Echols Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LERHINGI UN KNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Dille to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p as use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached The law requires that the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0026262 Hour 30. Name and address of person v ho completed cause of death (Item 23a) (Type, Print) Samue1 Kleiman 6362 Dockser St., Falls Church, VA 22041 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar Barks

DHMH 17 Rev 1/2001

			1 - For State of Maryland / Department / Department	artment of Health and Me		ene g. No. 2009 38	3442
	Physici	an	1. Decedent's Name (First, Middle, Last)		. Date of Death	Day Year	e of Death
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	Zami		41905 Clover Hill Court	Hollywood		St. Mary's	
I	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day,	9. Birthplace (Sta Country)	te or Foreign
	Director		Usual Residence of Decedent)2/22/19	New York	
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	e Mar a-f sl	Director	Maryland St. Mary's Hollywood			1 □Y	es 2 ∏ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?	
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	fter de ritem iner r	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - American Indian Black, White, etc.	,
9200-61212	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, it a Mydical Evaminer must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □Yes 2 □XNo Specify:		Specify: White	
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e, ≅	o ‡ t: 	1	Paula Heller/Wife 41905	Clover Hill Court	Holly	wood, MD 20636	
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			23a, Part 1. Enter the disease, or complications that caused the death. Do not ent	22955 Hollywood Rd.			
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5	hysic this or	0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		5 Residen	ce 6 ☐ Other (Specify)	
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5	al or safter	Certification: T	4 ☐ Homicide determined building, etc. (Specify)	,,	City or Town,	State)	umber,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the death of t	n occurred at the time, date and place, and vestigation, in my opinion, death occurred	d due to the cau at the time, date	use(s) and manner as stated. e and place, and due to the caus	e(s)
	To the To the complete	Me		29c. License number	290	Date signed (Month, Day, Year)
	0		29b. Signature and title of certifier j ovid m Fullilump	234198		11/6/09	
	Perme		30. Name and address of person who completed cause of death (Item 23a) (Type, F		100	.0.4	
	Stat	e	David Federle, M.D. 24035 Three No 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	tch Rd., Hollywood,	, MD 206	36	
	Registra		NOV 12 2009 June 1. Ja	nes			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:20 A Alma Lee Hamilton November Ĭ8, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hughesville 13952 Oaks Road Charles Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) July 2,1929 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 420-38-6592 Hours 1 M 2 TXF 80 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Charles Hughesville 1 □Yes 2 No 10e. Street and Number 10q. Citizen of What Country? 13952 Oaks Road 20637 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No If Yes, Give Year or Dates White Specify Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bookkeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur J. Rawlinson Mary E. Horton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Hamilton, Sr./Husband 13952 Oaks Rd., Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Onnation 5 ☐ Other (Specify) November Queen of Peace Cem. Helen, MD 2009 21. Signature 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., of Funeral Service Licenses M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 YUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only on 2500 Hospital: Other: 4 \(\sum \) Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year)

Examiner that the death certificate be executed and burial-1 physician the burial attending ph for use as the signed by the a

Box 68760,

P.O. I

Division of Vital Records,

Physician:

or Attending

Examiner Physician/Medical þ Completed has page certificate Be

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, it is Medical Evanting.

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Important: If Item 27 Is
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Physician

/Medical

Baltimore, Maryland 21215-0036

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Director

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Be

After this Certification: To To the Hospita. Swithin 24 hours after death.
To the Funeral Director: After a fundately filled in by the fur

25. Was case referred to medical examiner' 1 ☐ Yes 27. Manner of Devi Natural 2 Accident

29a. Certifier

(Check only one)

5 Pending investigation 3 Duicide 6 ☐ Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

 Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the time date and place, and place and place. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

State Registrar

Medical

31. Date filed (Month, Day NOV 2

32. Registrar's Signature

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	1. Decedent's Name (First, Mide								Į	2. Date of D Month	Day		Year	3. Time of Death
lical	JOSEPHINE S. 4a. Facility Name (If not instituti		LEY reet and ni	umber)		4b. Cit	ty, Town, o	r Location		NOVEMB		County of	09 of Death	3:30 P
iner	WILLIAM HILL			umbory		45. 011	EAS		0, 2000.			ALBO		
1	5. Social Security Number	6. Sex	и 2I X F		n yrs. last birthda Yrs.	y) If Unc Month	der 1 Year ns Days	If Unde Hours	r 24 Hrs. Min.	8. Date of E (Month, I	Day, Year)		Coun	
r	091-14-4534 Usual Residence of Decedent			100	0 113.					SEPT.	18,19	09	MA	INE
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To	UNKNOWN	,						UN	KNOWN	1				
	19a. informant's Name/Relation	ship (Type	e. Print)		19b. Ma	iling Addre	ess (Street	and Num	oer or Rura	l Route Nun	nber, City or	r Town, S	State, Zip	Code)
	CANDIDA WOLFF-	VODDE	N/DAI		R 5201 20b. Place of Dis			WAY,		KA, C			Ciby or To	wn, State
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Registrar
DHMH 17 Rev 1/2001

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(PAUL R. JOINSON MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CH

11/16/09 Sa	1 - Record 1 -	Amend #10E,10F,19 AACO. Health Dept			Indelible Ink. Ensure partment of Health and	•	_				
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D66753 11/6/09	D66753 11/6/09	Vita vysicia is certi directe	overninor?	ospital:	- Other:		6 ☐ Other (Specify)				
D66753 11/6/09	D66753 11/6/09	on of adding Pt ath. r: After the funeral icate:	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigation		y work?	28d. Describe how in	ury occurred				
D66753 11/6/09	D66753 11/6/09	Division atternate or all pirecto ed in by the all Certif		28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office						
D66753 11/6/09	D66753 11/6/09	he Hospi in 24 hou ne Funer pleted fill	Check 2 Medical Examine	er: On the basis of examination and/or in	vestigation, in my opinion, death occurred:	at the time date and pla	ce, and due to the cause(s) and manner stated.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy M. Carstack up. 7807 Thdownter (slewy Dr 1 - A, Anna volus MD 2140) State 31. Date filed (Month, Day, Year) 32. Segistrar's Signatures	To the with To the comm	29b. Signature and title of certifier	ant		29d. I					
(1) (1) The M. M. Cartina 2002 Thinnels fals To I land A. We are a related	State 31. Date filed (Month, Day, Year) 0 0000 32. Legistrar's Signature	OIL INK!		npleted cause of death (Item 23a) (Typ	e, Print)	-A A	he us autor				
State 31. Date filed (Month, Day, Year) 0 2000 32. Segistrar's Signature	Registrar NOV 0 9 2009 June B. garles	State		32. registrar's Signature	parled	4 1-4, Anna 1843 MD 21401					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene20091 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:51PM LRI 21. ONNI November 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 24 Rock Creek Drive Elkton If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 5, 1945 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country)
est Virginia **Funeral** 100 M 2□ F 221-28-567 64 West Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show th and Mentel Hygiene. If is marked other than "natural", or flems 23a or 28a-1 ahov traumatic avant, the Mudical Examinar coust be notified at 1 ☐ Yes 2 ☑ No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Sireel and Number 10f. Zip Code 24 Rock Creek Drive 21921 United States Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Peges 1 and 2 should be filled within 72 hours after c Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic avant, the Mudical Exercit 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automobile Mechanic Automobile Dealership 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence J. Hunt Pebble Jarrell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda Hunt/Wife 24 Rock Creek Drive, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State November 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 25, 2009 Elkton, MD Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licenses 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No be detached for 4☐Pregnant at time of death 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Junknown icete has been sig 7, page 2 should b 1 ☐ Yes 2 ☐ No **Be Completed** 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3□ DOA 28a. Dale of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury s effer dea... rai Director: Afte 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - Al home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide • Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Fune completely fi (Check only one)

State Registrar 29b. Signature and title of ce

Name and address of

31. Date liled (Month)

DHMH 17 Rev 1/2001

rson who completed cause of death (Item 23a) (Type, Print)

Stanton

32. Registrar's Signature

29c. License number

Wozniak,

400

T.

29d. Date signed (Month, Day, Year)

			For State	State of Ma	aryland /	Depai	rtment	of Hea	Ith and M		-		38	448
		_1	Registrar			Cert	tificate	or De	airi T	2. Date of Dea	Reg. Now			of Death
Ph	ysicia	_	1. Decedent's Name (First, Middle, Last Dorothy Ileen							Month	Day	Year	110:4	1DIAM
	Medic	ai					4h City To	wn. or Loc	ation of Death	voveme		County of Deat		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
E	kamine	7	4a. Facility Name (If not institution, give	street and number)	Can	0.5			iland		A	llega	ny	
F			WmHS Braze 5. Social Security Number 6. Se		ge (In yrs. last	birthday)	If Under 1	Year If	Under 24 Hrs. lours Min.	8. Date of Birt (Month, Da	h v, Year)	9. Birt	hplace (Stat untry)	e or Foreign
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ъ	_		Usual Residence of Decedent		10c. City, To	own or Loc	ation						10d. Inside	City Limits
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he Ma	all a	ecto	10e. Street and Number				10f. Zip C	ode			10g. Citi	zen of What Co		
with t	De la	Funeral Director	104 Gilmore St	reet				2672	:6			U.S.A	•	
eath	IS 23	nera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decede	nt of Hispa	nic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit		
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vithin ene.	e Me	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		ail c				Clo	othing	Stor	'e
Hygi	ant, III		17. Father's Name (First, Middle, Last)						. Mother's Name				• •	
d be ental	ic eve	To Be	Parley Diehl						Katheri					
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	umat		19a. Informant's Name/Relationship (19b. Mailin	g Address (Street and	Number or Rur	al Route Numb	er, City o	or Town, State,	Zip Code) 6726	
and 2	ertra	M	lichael Maine/ne	phew					na Ave	o, Key		ocation - City or		
of He	r item		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □	Removal from State	20b. Plac	e of Disponetery, cren	sition (Name natory or oth Memo	ner place)	1	23/09		yser,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.	tant: jury c		4 ☐ Donation 5 ☐ Other (Specify	<i>(</i>)	POL		. Name and		1		IXC.	, 502,		
Dermit Depar	any in		21. Signature of Funeral Service Licer	1		ĺМ	arkwa	and 1	Funerai	L Home	, I1	nc.		
			23a. Part 1. Enter the disease, or com	olication u at cause	ed the death.	Do not ent	er the mode	of dying,	such as cardiac	or respiratory	arrest,	20/20	Approxi	Between
			shock, or heart failure. List only	one cause on each	11110.		vnam		m bolis				Onseta	nd Death
	ician edical		disease or condition resulting in death)	a	s a consequer									15
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequer	nce of):								
scuter	ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequer	nce of:								
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b8/t	physic the t	dical	•	d										
certifi	signed by the attending pr d be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon	ne of pregnanc	су	7 e a mai d					23d. Date of d		Vee
BOX death cer	atter I for u	iciar	in the past 12 months?	4 🗌 Pregnan	n 2 ☐ Fetal d t at time of dea	eath 31 ath 5[Ctopic pi					Month	Day	Year
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<u>ਜੂ</u>	page	Completed								1 ☐ Yes	2 L/N	1 □Y	es 2□No	
VITA	this certificete has al director, page 2	B	25. Was case referred to medical examiner?	Hospital:	atient 2 ☐ E	D/Outratio		Other	26. Place of Dea			6 ☐ Other (S	necify)	
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Div To the Hospital or within 24 hours afte	To the Funeral Director: completely filled in by the			hysician: To the be miner: On the bas	is of examination	rledge, dea on and/or i	ith occurred investigation	at the tim	e, date and plac inion, death occ	e, and due to t urred at the tim	ie, date a	ind place, and	due to the ca	use(s)
To the I	the mplet	Medical	one) 29b. Signature and title of certifier	and manner	Stated.		29	c. License	number		29d. [ate signed (Mo	onth, Day, Ye	ear)
₽ 5 ₹	5 8							92	1244		1	1/19/	200	9
			30. Name and address of person who	completed cause	of death (Item	23a) (Typę	, Print)		-	1	la :	1/19/	7:1	.00
			Jesus TAN.	MD.	4 Br	pad	wa	4.1	-1054	DURG	1/1	0	X10	02
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5 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Joe Preston Horst November 20 2009 11:50 A.M/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Mennonite Fellowship Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 16 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1919 Months Days Hours 1 M 2 □ F 216-14-6058 90 Maryland Director Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
The Health and Mental Hygiene has "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD. Washington 1 ∐Yes 2 XX No Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 U.S.A. 12349 Huyett Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or iten ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey B. Horst Barbara A. Martin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 Rohrersville Rd. Knoxville, Md. 21758 Edith Myers/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt_Olive_Mennonite
Church_Cemetery permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/24/09 Maugansville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. - Martin 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for a in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe page Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the mospher.

within 24 hours after death.

To the Funeral Director: After this of P 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar ed (Month, Day, Year)

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

580 C NORTHERNAUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 - For State Registrar	State of Maryland /	Certificate of L		Reg. No. 2009	38450
Physician	1. Decedent's Name (First, Middle, Las	t)		2. Date of Do Month	Day Year	3. Time of Death
/Medical	W	<u>illard Lee Headr</u>		Novemb		0137 A ^M
Examiner		street and number)	4b. City, Town, or		4c. County of Death	
	Union Hospital 5. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 8.	ex 7. Age (In yrs. last b	Elkton	If Indox 24 Hrs. 0 Date of D	i de la Carte	place (State or Foreign
Funeral Director		X м 2□ F 79	Yrs. Months Days	Hours Min. May 24	Ay, Year) Cou 1, 1930 A1	abama
land	10a. State 10b. County	10c. City, To	wn or Location			10d. Inside City Limits
Mary -f sh	Maryland Cecil	E1kt	r on			1 XYes 2 ☐ No
or 28a-f sl	10e. Street and Number	131111	10f. Zip Code		10g. Citizen of What Cou	ntry?
h with		urt	21921		United S	States
Ster death v	11. Marital Status	12 Was Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.)	o- 14. Race - Ameri Black, White,	ican Indian, etc.
D36	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? Korea 1 MYes 2 □ No If Yes, Give Year or Dates:	1 □Yes 2 X No	Specify:	Specify:	ite
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nd oth Heaven	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle		
Vla ould I Men marke natic				Ruby Pearl Med		. 0-1-1
Mar 2 sh h and 7 is n rraum	19a. Informant's Name/Relationship ("		and Number or Rural Route Num		rp Code)
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Itin sit. Pa artme ortani injury	4 ☐ Donation 5 ☐ Other (Specify 21. Sign 1 re of Funeral Service Licen	// Memõi	rial Park_	24, 2009		MD
Ba perm Imper any any	Donaid	B- Hickory	Hicks Home 103 W. Sto	s of Facility for Funerals, ckton Street, E	P.A. Elkton, MD 2	1921
Physician /	23a. Part 1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death. Done cause on each line. a. Vue to (or as a lonsequence)	ula T	g, such as cardiac or respiratory	orrest,	Approximate Interval Between Onset and Death
I Records, P.O. Box 68760, The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burlat-transit accompleted by Physician/Medical Examiner		b. Due to (or as a consequence of the following to the following the fol	esmisa	tory your	Line	15 years
Cords, P.O. Box 6 w requires that the death certifiches is been signed by the attending I should be detached for use as letted by Physician/Meleted by Physi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		,	23d. Date of deli Month	very Day Year
S, P, S, P, igned by be deta		ontributing to death but not resulting	g in the underlying cause give	</td <td>tobacco use contribute to</td> <td></td>	tobacco use contribute to	
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al Record The law requir cate has been s page 2 should	(/	24a. Wa	as an 24b. Were au prior to death?	topsy findings available completion of cause of
The The page				per 1 □Yes	formed? death? 2 ☑ No 1 ☐ Yes	2 🗆 No
Vital Sician: T certifical rector, pa	25. Was case referred to medical		Tou.	26. Place of Death (Check only	r one)	
구 불 발 로 2	1 Yes 2 No	Hospital: 1 Impatient 2 ER/		4 Nursing Home 5 Re		cify)
Ing F	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	(Month, Day, Year)	b. Time of linjury 28c. Injury Work		e how injury occurred	
Division of Division of Division of tall or Attending P is after death. al Director: After led in by the funers led in by the funers Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			Yes 2 □No 28f. Location City or T	(Street and Number or Ru own, State)	ıral Route Number,
		nysician: To the best of my knowled	dge, death occurred at the tir	ne, date and place, and due to the pinion, death occurred at the time	ne cause(s) and manner as	s stated.
the Hosp ithin 24 hou the Fune ompletely fil	one)	and manner stated.				
To t To t COURT	29b. Signature and title of certifier	Pal-1C Vals	29c. Licens	2 3 0 7	29d. Date signed (Month	8 2009
8+1	30. Name and address of person who	completed cause of death (Item 23	a) (Type, Print)	2-307 RY AVE, E	ELKTONY, D	11)21921
State Begistrar	1 1 1 2 Z UM 3	32. Registrar's Signature	Barel		/	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ FRED CHARLES INMAN, SR. 2009 ʹ6 11:50 NOvember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN NURSING & REHABILITATION BERLIN 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours Min 1 🛛 M 2 🗆 F 3-28-1918 OTHO 91 280-14-7754 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1X Yes 2 ☐ No MARYLAND BALTIMORE BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3905 DARLEIGH RD 21236 US 12. Was Decedent Ever in U.S. Armed Forces? 1 🗓 Yes 2 🗌 No If Yes, Give Year or Dates. 1942 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) OFFICER MILITARY should be filed with and Mental Hygien 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai ARIANNA M. BAYNE/GRANDDAUGHTER 6828 PROVIDENCE SQUARE DR, APT. 257, CHARLOTTE, NC. 2827 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State MELSONS CREMATORY 11-11-2009 FRANKFORD, DELAWARE 4 Donation 5 D Other (Specify) 2. Name and Address of Facility LSON FUNERAL SERVICES, LTD. THATCHER STREET, FRANKFORD ignature of Fun DELAWARE. 19945 hase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Approximate interval Between Onset and Death shock, or heart fa Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 2.N has certificate completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA after death. Director: After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined

State Registrar

within 24 hours a To the Funeral I

Medical

29a. Certifier

29b. Signature

en

31. Date filed (Month, Day, Year)

(Check only one

and title of certifier

NOV 12

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Baltilli 84; Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Berlin

mal.

Registrar

9:15 A

State of Maryland / Department of Health and Mental Hygiene Reg. No 2009

4c. County of Death

Montgomery

2. Date of Death

1. Decedent's Name (First, Middle, Last)

1 - For State Registrar

Physician

Examiner

/Medical

DORIS PATRICIA JOHNSON 4a. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

Bethesda

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

 Birthplace (State or Foreign Country) MD

10d. Inside City Limits 1 ☐ Yes 2 🛣 No

10g. Citizen of What Country?

November 2, 2009

14. Race - American Indian, Black, White, etc.

Specify: Black 16b. Kind of Business/Industry

Lockheed Martin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20c. Location - City or Town, State Silver Spring, MD

246 N. Washington St, Rockville, MD 20850

23d. Date of delivery

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

3 ☐ Probably 4 ☐ Unknown

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) ZONA

ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add

8600 Old Georgetown Rd, Bethesda, MD 20814 Atul Rohatgi

State

32. Pagistrar's Signature

	<					. Ensure All Copi								
	AMENDE	n #		tate of Maryland	Department of I Certificate of	Health and Mental I								
15	THI IBIVED	, 11	Registrar J, 111, 1011 D, 117 Decedent's Name (First, Middle, Last)	10/09,115	Oertineate of	2. Date of	Reg. No. 2009	3845						
	Physic /Medi	cal	Wesley		USON	Month	Day Year	2145 M						
1	Exami	ner	4a. Facility Name (If not institution, give street Chester Rive		or ches		4c. County of Death	nt						
ı	Funeral Director		5. Social Security Number 6. Sex	2□ F 7. Age (In yrs. la	Ast birthday) If Under 1 Year Yrs. Months Days	Hours Min (Month	Birth 9. Birth Cou.	** 1						
	land ow It		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Location			10d. Inside City Limits						
	e Mary ta-f sho tified a	ctor	Md. Kent	\ \frac{1}{V}	Vorton			1 ☐ Yes 2 No						
	with the	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?						
	ns 234 must	Funeral	11.58 Oak Lane	Was Decedent Ever in U.S	2 / 6		USA No- 14. Race - Americ	can Indian						
5-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by	1 Never Married 2 Married	Armed Forces? 1	If Yes, specify Cub	dispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:	Black, White,							
5-0	72 ho "natur dical	eted	15. Decedent's Education (Specify only highest grade control of th	on mpleted)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working	16b. Kind of Business/In	dustry						
d 2121	d 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) Unkinwn 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Construct		Constr	uction						
Maryland	Mental Mental arked o	To Be	David	Johnson		Susan	ale, Malderi Surname)	.						
lary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type. I		19b. Mailing Address (Street	and Number or Rural Route Nu	ımber, City or Town, State, Zip	90de)						
	is 1 and of Health item 27 other tr		Doris Johnson 20a. Method of Disposition	/ wife	11158 Oak Lo	ine, Worton,		>						
altimore,	g = 5°		1 Burial 2 ☐ Cremation 3 ☐ Remo	oval from State ce	ace of Disposition (Name of metery, crematory or other pla		20c. Location - City or To	•						
altin	permit. Pa Departmen Important: any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Em	manuel Church 22. Name and Addre	Cem. 11-13-00 ss of Facility Bennie!	Yamona,	Md						
ä	permi Depa Impo any ir		Tassial 1	1 tilghma	Road 29		un, Ind. 2165							
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicatic shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ons that caused the death. ause on each line. Due to (or as a consequit	bon	ng, such as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death						
8760,	ate be executed hysician and the burial-transit	dical Examiner							Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	Due to (or as a conseque				
P.O. Box 687	The law requires that the death certificate be ten has been signed by the attending physicionage 2 should be detached for use as the but	Physician/Medical	in the past 12 months?	f yes, outcome pf pregnan I □Live birth 2 □ Fetal o I □ Pregnant at time of dea I □ Unknown	leath 3 ☐Ectopic pregnancy	/	23d. Date of delive Month	ery Day Year						
or Vital Records, P	w requires that the de been signed by the s should be detached t	þ	Part II. Other significant conditions contribut O Smell Bowel	Obstruction	n D Serval		id tobacco use contribute to ti □ Yes 2 ☑ No 3 □ Prob	he cause of death?						
ecc	ne law re has bee je 2 sho	Completed	bed some B BPH	Tobstructio	n @ HTN	24a. W		psy findings available mpletion of cause of						
<u>=</u>			1 PAD, S/P Bilatual	AKA OBL	ndness ou.	pe 1□ Ye	erformed?/ death?	·						
Zit.	siclar certif	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospi	tal:	P/Outpatient 3D DOA Oth	26. Place of Death (Check onliner:								
יס ר	Attending Physician: The r death. ector: After this certificate h. y the funeral director, page	n: To	27. Manner of Death 28	Ba. Date of Injury 2	28b. Time of 28c. Injur	yat 28d. Describ	esidence 6 Other (Specification of the following security security of the following security of the following security of	y)						
sior	tendin sath. or: Aff	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Wor M 1 □	k? Yes 2 □ No								
É	tal or Attrassive all Directration by ted in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28	Be. Place of injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Location City or	n (Street and Number or Rura Town, State)	l Route Number,						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	lical	one) Z wedical Examiner:	On the basis of examination	on and/or investigation, in my o	ne, date and place, and due to t pinion, death occurred at the tin	ne, date and place, and due to	tated. o the cause(s)						
•	To t To t	Z	29b. Signature and title of certifier	np.	29c. License	e number	29d. Date signed (Month,	Day, Year)						
	3		30. Name and address of person who comple	ted cause of death (Item 2	3a) (Type, Print) Ave., Cheste	istown, MD 2	21620							
	Sta Registr	te ar	31. Date filed (Month, Day, Year) NOV 1 0 2009	32. Redistrar Signatu	b. parl									
DHN	MH 17 Rev 1/20	01												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First Middle Last) Physician /Medical or Location of Death 4c. County of Death Examiner N/A9. Birthplace (State or Foreign 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Year) **Funeral** Days Hours 1958 MD 51 9 Director 6 214-68-5131 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 7 is merked other than "natural", or items 23e or 28e-f show traumatic event, the Wedical Exa., that we natified at 1 ☐ Yes 2 XNo Wicomico Salisbury Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 21801 1812 Thomas Lane 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔯 No Specify: SpecifyBlack þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is merked other than 'gay Injury or other traumatic event, Item Man Elementary/Secondary (0-12) College (1-4or 5+) Laborer Industrial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernice Johnson Alvin Carney ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grace Johnson/Wife 1812 Thomas Lane, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Direct Crematory, 11-16-2009 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 917 W. Isabella St Bennie Smith 21. Signature of Funeral Service Licens Salisbury, MD 21801 Funeral Home disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part Cinter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) seps **Physician** 15 /Medical or as a consequence of): Examiner embolism MORON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physicien: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? s been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **1** No 1 □Yes Be 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: /d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral D e Funeral D letely filled in 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 RES-000 re and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore Babak Tabatabo 31. Date filed (Month, Day, 32. Registrar's Signature State NOV 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 16 November 2009 9:09P Connie Margaret Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea April 3, 1 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Months Washington DC Director 213-82-8718 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director La Plata MD Charles 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Edelen Station Place 20646 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 <u>Account Representative</u> Health Centers permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Kite Jeannette Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Kite/Mother P.O. Box 219, Bryantown, MD 20617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burlal 2 🗆 Cremation 3 🗆 Removal from State Trinity Memorial Gar 11/21/09 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00945 ²²AREHART-ECHOLS FUNERAL HOME, P.A. Have Cohu 211 St. Mary's Ave. La Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner nfected decubitus ulces unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 End stage renal disease Records, cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed History of Mutrillin resistance statt auron 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this in by the funeral dii 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) Reistan Family D43446 M.O 11.17.09

State

Registrar

Box 68760

P.O.

ROINTAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EARAHIEAR

12150 Annapolis road, suit 312 Glenn dal. MD 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year 333 AM ROSALIND SCHRIBMAN KELMAN NOV 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Howard County General Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 4, 1935 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 M 2 F Minnesota 74 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Fulton 5 4 1 1 ☐ Yes 21 No Howard Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20759 United States 6955 Pindell School Road, P.O. Box 564 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 🕍 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Law Firm Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Berg Joseph Schribman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip, Code) 6955 Pindell School Rd., P.O. Box 564, Fulton, MD 19a. Informant's Name/Relationship (Type. Print) Harvey Kelman, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/09/09 Olney, MD Judean Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Enhant Service Licensee forching to Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part Frier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIO SHOCK resulting in death) Due to (or as a consequence of) BOWEL ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): INTESTINAL STRANGULATION Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 🖼 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENION 27 No 1 ☐ Yes 3 Probably 4 Unknown HYPERCHULESTERVLEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes 2 □No 6 ☐ Could not be

Physician /Medical Examiner Examiner

Physician

/Medical

Funeral

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Completed

Be

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. In the Maryla Important: I flem 7 is marked other than "natural" or items 23a or 28a-1 show any Injury or other traumatic event, the "hecical Exercitive must be rectified at

Pages 1 ment of F

3altimore, Maryland 21215-0036

ng physician and as the burial-transi attending nse the signed by has

P.O. Box 68760, certificate be

Division of Vital Records,

After this certificate To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Physician/Medical 9 Unknown Completed by Be

Hospital or Attending Physician: 12

25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 17 Natural 2 Accident 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of cortifier

29c. License number D0043662

29d. Date signed (Month, Day, Year) NOV 8 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane, Columbia, MD 21044 B0418 HOWARD (O GEN HOSPITAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 2, 2009 Charles W. Kerns 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death

7. Age (In yrs. last birthday)

10c. City, Town or Location

Waldorf

69

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates:

½□ M 2□ F

Waldorf If Under 1 Year | If Under 24 Hrs.

Days

10f. Zip Code

1 □Yes X□No

20602

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

Physician /Medical Examiner

1 - For State Registrar

10a. State

Maryland 10e. Street and Number

11. Marital Status

Director

Funeral

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24 Mooncoin Circle

24 Mooncoin Circle

1 Never Married 2 Married

3 Widowed 4 Divorced

10b. County

Charles

5. Social Security Number

579-52-2115

Usual Residence of Decedent

Funeral Director

show Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be rectified at Health a ₽

Pages 1 and 2 should be filed within 72 hours after altimore, Maryland 21215-0036 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Industry Stock Clerk 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E. Crampton Charles U. Kerns ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24 Mooncoin Circle, Waldorf, MD 20602 Ethel T. Kerns/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November Department of Important: If It any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4 □ Donation 5 □ Other (Specify) 4, 2009 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Ligensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 chis — MOO817 23a. Part 1. Enter lie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Elike of carrier Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performed?

1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated within 2 29b. Signature and title of certifier o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

29d. Date signed (Month, Day, Year)

23d. Date of delivery

10:45 p. M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No

Washington, DC

Charles

10g. Citizen of What Country? USA

14. Race - American Indian, Black, White, etc.

White

8. Date of Birth June 28, 1940

Tochecardia

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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ir than "natural", or items 23a or 28a-f sho the Medical Examinat must be notified at

other traumatic

Department of Health a Important: If Item 27 is any injury or other trainonce.

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

10a. State

P.O. Box 68760;

Division of Vital Records,

Physician/Medical Examine

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Certification: To Be Completed

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

resulting in death)	Due to (or as a conseq	-	1	4		2 - 0
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence DA 40 C		Inform	tim		2 months
that initiated events resulting in death) Last	d.		tery de	sase		SYERS
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3 □ Ectopi	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions co	ntributing to death but not res	A	g cause given in Part I.			to the cause of death? Probably 4 Unknown
Hypertensi.	n, C	ulm (Cancer	24a. Was an autopsy performed	prior to	
25. Was case referred to medical examiner?			1	eath (Check only one)		
1 Yes 2	Hospital: Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Sp	ecify)
27. Manuer of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, St		Rural Route Number,
	rsician: To the best of my knowiner: On the basis of examinated and manner stated.					
29b. Signature and title of certifier	Hakim	mo	29c. License number	4 Q 29d.	Date signed (Mon	nth, Day, Year)

prig

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
7501 Surratts Rd., Clinton, MD

Denve D. park

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 1:00 P M **Physician** November 15, 2009 Edward William Kraus /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 91 vrs 5. Social Security Number Days **Funeral** Months Hours 1 XM 2 ☐ F May 15, 1918 Ohio 310-03-5705 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Prince Frederick Maryland Calvert Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20678 USA 4100 Valley Lee Court Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1943— Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🛱 No Specify: White 1945 Specify Baltimore, Maryland 21215-0036 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Farming Farmer 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked ofth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Susan Bachman Edwrd W. Kraus ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elaine Kraus Steib/Daughter 4100 Valley Lee Ct., Prince Frederick MD 20678 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lebanon Cemetery November 20 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Lebanon, Ohio 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ZHEIMEL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner attending physician and for use as the burial-transit Examir death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a d be detached f P.0. Hospitai or Attending Physician: The law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STENOSIC cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? FAILURE 24a. Was an autopsy performed? Yes 2 No 2 No 1 □Yes After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 □Yes 2 □No nours after death.

neral Director: Af

filled in by the fur 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11.16.2009 D67788 MD Johns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KODALI, Charlotte Hall, MD RAO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EURGE (1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 212-18**-**2137 90 Yrs **Director** 11/11/1918 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Wedical Examinar must be notified at 1 □Yes 2 No Funeral Director South Carolina Myrtle Beach Horry 10g. Citizen of What Country? 10e. Street and Number ò 2960 Duck Ct., #20 or items 23a USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. rmed Forces?

XYes 2 □ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: W.W. 1 ☐ Yes 2 🕅 No Specify: Completed by Specify: White 3 ₩ Widowed 4 □ Divorced II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Federal Government Aircraft Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F is marked otl John Klem Anna Toma ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health of Hea Valerie A. Fleming/ Daughter 3402 Narrows Ct., Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o once. o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Signature of Fineral Service Licensee Kalas Crematory 11/6/09 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home VILLE 2973 Solomons Island Rd. Edgewater, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1-Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state. (Check only 29b. Signature and title of certifier 29c. License number mpleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day LESLIE DEANN KING 1:25P NOVEMBEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Days Hours Min (Month, Day, Year) 10/10/1966 Months Director 419-13-3936 43 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d, Inside City Limits Director 1 X Yes 2 ☐ No PA Adams Fairfield 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Finch Trail 17320 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Research Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Posey Blanche Louise Moore permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. King/Husband 5 Finch Trail, Fairfield, PA 17320 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State ö injury (4 Donation 5 Other (Specify) Geisel Funeral Home 11/25/09 Chambersburg, PA 17201 Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman & Son Funeral Home 45 S. Carlisle St. Greencastle, PA 17225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) POXIC oisa Medical Due to (or as a consequence of) Examiner week preumonia Sequentially list conditions. Zun tu (ur ex a consequence of) cause. Enter Underlying Exami or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury Metastatic Cance and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy for in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant a
9 ☐ Unknown detached 9 🗌 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ! performed' 1 ☐ Yes 2 ☐ No Yes 2 🔀 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 Nn မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

completed filled in by the funeral director, n 24 hours after deat e Funeral Director: the Hospital within 2

> State Registrar

Medical

29a. Certifler

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ulu haar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 7/2009 DIL

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Frederick

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0062975

MD

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29d. Date signed (Month, Day, Year) 11/23/200

29c. License numbe

State of Maryland / Department of Health and Mental Hygiene Stephen Philip Kulina 2009 38462 Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1616 hrs November 18, 2009 Medical Examiner Stephen P. Kulina 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown I-81 Northbound of Exit 5 If Under 1 Year | If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Social Security Number 6. Sex **Funeral** Country) Months Days Hours Director 217-80-9656 12/06/1960 Canada 48 1XMYrs 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 X No 23a or 28a-f show notified at once. 9832 Garnes Road, Montgomery Township Franklin Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Numbe 17236 9832 Garnes Road or items 23a or must be notif 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. White Armed Forces? Never Married 2 X Married Yes If Yes, Give Year Specify: Yes 2 X No specify Widowed Divorced "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Medical Baltimore, MD 21215-0036 is marked other than Document Shredding Co Vice Pres. Operations 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, t Joseph Stephen Kulina Sr. Marlene Lehman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kulina 9832 Garnes Road, Mercersburg, PA. 17236 (wife) If item 27 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition -27-2009 crematory or other place) Burial 2 XCremation 3 Removal from State Thomas L. Geisel Crema torium Chambersburg, PA. Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Thomas L. Geisel Funeral Home M01346333 Falling Spring Road. Chambersburg Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical physician a UNPENDED AMENDED Records, P.O. Box 68760, The law requires that the death certificate be 23d. Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death icate has been signed by the attending page 2 should be detached for use as 2 past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 V Yes certificate After this certific funeral director, p To the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Division of Vital Be examiner Hospital: 1 Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Driver in a motorcycle to fixed object collision Certification: Nov 18, 2009 To the Hospics... within 24 hours after death.

To the Funeral Director: A 1610 hrs Natural Yes 2 V No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide I-81 NB Exit 5, Hagerstown, MD determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie November 19, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day Year)

State Registra

			1 - State of Maryland / Department of Health a Certificate of Death	and Mer	ntal Hygie Reg.	ne 2009	38463	
	Physici	an	1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month OV 14,20	Day Year	3. Time of Death	
	/Medic Examir	cal	James L. Little 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of			4c. County of Death	12:19 №	
4	LXaiiii		Charlotte Hall Veterans Home Charlotte Ha	all		St. Ma		
	Funeral Director		5. Social Security Number 243 20 7419 Usual Residence of Decedent 6. Sex 1	Min.	Date of Birth (Month, Day, Yes uly 22,	9. Birtr Cou 1925 Oh:	place (State or Foreign ntry) LO	
	yland how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
	8a-fs	Director	MD Anne Arundel Severna Park		.,		1 □Yes 2 XNo	
	with the sa or 2	Dir	10e. Street and Number 277 Lower Magothy Beach Road 10f. Zip Code 21146	6		Citizen of What Cou United Sta	•	
(0	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Exemplicat must be redified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Mar			14. Race - Ameri Black, White,	can Indian,	
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Maryland 21215-0036	uld be file Mental Hy arked oth atic event	To Be			rst, Middle, Maid Warren	den Surname)		
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Expeditor must be neutrified at once.		4□Donation 5□Other (Specify) Maryland Veterans Ceme	-	Che	.Location - City or T eltenham,	MD	
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B	B1081	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA RAO KODALI 29449 Char lotte Ho	allRa	d Cha	nlotte	-22 -1AII mc/	
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Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injux or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee		22	. Name and Addres	s of Facility					37
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	001		30. Name and address of person	who completed cause o	f death (Item	23a) (Type, P	rint)						
			Stephanie Trifo	oglio 7500	Greenw	ay Cer	ter Drive	e Suite	430 Gr	eenbe	elt, Mc	207	70
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 4a. Facility Name (If not institution, give street and number) 0758 A 02 /Medical November 2009 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, April 1, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Year) 1 x M 2 □ F Director 1925 577-32-8609 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Mudical Examinar must be notified at 1XYes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 North Leisure World Blvd #726 20906 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1XYes 2□No WWII 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Health and Mental Hygiene. tem 27 Is marked other than other traumatic event, the M College (1-4or 5+) District Manager Drapery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Laten Ida Levine ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Laten/Son 117 Dauntley Street Kettering, Maryland 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
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Important: If ite
any injury or ot 13€ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grds. 11/06/2009 | Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilitanzansky-Goldberg Memorial Chapels 21. Signature of Funeral Service Licensee Jamie Arthurs 1170 Rockville Pike Rockville, Maryland 20852 MOIL63 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ending physician and use as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Ye ar 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been funeral director, page 2 should Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, Division of Vital Records,

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

•				24a. Was an autopsy performed? 1 □ Yes 2 ☑No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2√2No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 █ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ [OOA Other: 4 I Nursing	Home 5 ☐ Residence 6	G □ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	
3 Suicide 6 Could not 4 Homicide determined		nome, farm, street, facto	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1. ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of my kn miner: On the basis of examin	owledge, death occurre ation and/or investigation	d at the time, date and pla on, in my opinion, death oc	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

M0000335

29d. Date signed (Month, Day, Year)

November 02, 2009

State Registrar

Medical

29b. Signature and title of certifier

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Olney, MD 20832 NOV 1 0 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar MD, TCHD, pha 11/05/09 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Jeanette Ethel /Medical 2009 9:45a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Pines Genesis HealthCare Talbot Easton Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 68 212-40-9811 July 18,1941 Maryland Usual Residence of Decedent 10a, State 10c, City, Town or Location 10b. County show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f should employ the Madical Examiner must be notified at Director 1 X Yes 2 □ No Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29746 Penny Lane Funeral 21601 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 図 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify White þ Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, It e Medical Exp. 9008. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Elbert Richards Ethel L. Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Mitchell/daughter 32803 Bluff Point Dr., Cordova, MD 21625 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Nov.11,2009 Federalsburg, MD 21. Signature of Funeral Service Lens 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD 21601 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** indans disease or condition resulting in death) /Medical Due to (or as a consequence of); **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed rsician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past +2 months? 1 ☐ Yes 2. No Month Day Year 5 Other (specify) P.O. ed by the detached 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Records, of Vital Division Hospital or Attending 24 hours after death.

Funeral Director: 4 within 2 To the I

> 10 State Registrar

(Check only one)

29b. Signature and title of certifie

Michael

610 Dutchman's Lane Easton, MD 21601 31. Date filed (Month, Day, Year) NOV 0 5 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Crowley

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILBERT GEORGE LAIRD 2009 NOVEMBER 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner TALBOT 18 NORTH AURORA STREET EASTON If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 168-05-8628 91 Yrs Director 12/06/1917 PENNSYLVANIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Medical Examinat must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18 NORTH AURORA STREET 21601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If ¥es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 □Yes 2 No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REFINISHER FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIZABETH C. ZIBRAT GEORGE ALOYSIUS LAIRD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 NORTH AURORA ST., EASTON, MD, 21601 MARY C. LAIRD/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NATIONAL 01-14-2010 ARLINGTON, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, sinch as cardiac or respiratory arrest, lemediate Course (7). Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dilated Cordionyo **Physician** _/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3₽Probably 4☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been s rector, page 2 should Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10023922 MI 700g TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+VA Buther Preston ND 21658 136 Ledrum Arc nelinda

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NUV U & 2009

32. Registrar's Signature

			for State Registrar	State	of Marylar		artment o rtificate o			fental Hyg R	iene eg. No. 🥎 (200	20166
	Physic		1. Decedent's Name (First, Middle	.,,		-				2. Date of Deat Month	Day	year	3. Filme of Death
	/Medi Examir		4a. Facility Name (If not institutio	n, give street and n	umber)		4b. City, Tow		on of Death	Novembe	4c. Count	y of Death	7:17 p
	Funeral	_	690 Armiger Ro 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Hunting If Under 1 Ye Months Da	ear If Un	der 24 Hrs.	8. Date of Birth (Month, Day,	Calv	9. Birth	place (State or Foreign
	Director		578-50-2632 Usual Residence of Decedent	1 □ M 2 X F		76 Yrs.	Months Da	ays Hou	rs Iviin.	March 1		Coui	SC
	yland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
	e Mar 8a-f s	Funeral Director	MD Calv	ert	Н	untingto							1 □ Yes 2 No
	a or 2	Dire	10e. Street and Number				10f. Zip Coo				0g. Citizen of	What Cour	ntry?
	ns 23	eral	690 Armiger Ro 11. Marital Status		cedent Ever in U	.S. 13. \	2063		Origin? (Sp	ecify Yes or No-	USA 14. Ra	ce - Americ	can Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any hirury or other traumatic event, I'll. Medical Examiner must be notified at once.	<u></u> ≥	1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	ried Armed F	orces? 2 X No iive		fYes, specify (I∐Yes 2	Cuban, Mex	ican, Puerto	Rican, etc.)		ick, White,	
2-0	72 hou	Completed	15. Deceder (Specify only highe	nt's Education)	16a. Deced	ient's Usual Oo kind of work do	ccupation	nost of work	ina	16b. Kind of B		
121	within iene. than	ldm	Elementary/Secondary (0-12)		(1-4or 5+)	life. I	DO NOT use re	tired)		9			
	filed v Hygie other t		17. Father's Name (First, Middle,	Last)	5+	1		Teache 18. M		e (First, Middle, I	Public S Maiden Surna		S
<u>a</u>	Aental Aental rked c	To Be	Johnnie McMicl					Mi	nnie Yo	una			
Maryland	2 shou and N is ma auma	-	19a. Informant's Name/Relations			19b. Mailir	g Address (Str			al Route Number	City or Town	, State, Zip	Code)
	l and Health Im 27 Ther tr		Vivian E. Perry	Cooper - da	aughter	P,C	. Box 10	57, No		ch, MD 20	0714	O': T	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'amp Injury or other traumatic event, the "Mede.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation		State 20b. F	Place of Dispo cemetery, cren	sition (Name on atory or other	place)		Date	20c. Location	- City or To	own, State
i	permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (S				n Veterar . Name and Ad		oility.	er 18, 2009 (D
B	permi Depar Impor any Ir		Dlaglie a	7. Sew	ell				Sev	well Funera Prince Fre			7Ω
and the	Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	each line.	h. Do not ent	er the mode of		as cardiac		est,		Approximate Interval Between Onset and Death
38760,	physician and interpretation in the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to	(or as a conseq	uence of):							
O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending pring director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregna birth 2 ☐ Feta gnant at time of c nown	ldeath 3□] Ectopic pregn] Other <i>(sp</i> ec <i>if</i>)					ate of deliver	ery Day Year
rds, P.	quires that n signed b	þ	Part II. Other significant condition	ons contributing to a	leath but not res	ulting in the ur	derlying cause	given in Pa	ırt I.				he cause of death?
Records,	: The faw requireate has been single 2 should	Completed	pypu	eter-sion	1					24a. Was an autops perform	v	Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Vital	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. PI	ace of Death	1 □ Yes 2 n (Check only on		10163	26110
of V	hysic this call dire	2	1 Yes 2 No		Inpatient 2		1 3 1 1004			me 5 Reside		((y)
Division	ding After funer	Certification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	gation	nth, Day, Year)	28b. Time of Injury	М	njury at Vork? 1 □ Yes 2		28d. Describe ho	w injury occur	red	
Divi	ospital or Attendi hours after death, uneral Director: A ly filled in by the fi	Certifi	4 ☐ Homicide determ	ined 286. Plac build	e of Injury - At ho ling, etc. (Specif					City or Towr	, State)		al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical one)		e best of my kno basis of examina nner stated.	wledge, death tion and/or inv	estigation, in r	ny opinion,	death occur	and due to the c red at the time, d	ause(s) and mate and place,	and due to	stated. the cause(s)
	Nith To 1	2	29b. Signature and title of certifie	Mon	nns	\geq	29c. Lio	ense numb	er -43		9d. Date signe	ed (Month,	Day, Year)
<u>LRV</u>	15		30. Name and address of person	who completed cau	1/	n 23a) (Туре, I М. D.	Print)		Prin	ice Fre	teric	KI	1D 20678
	Sta	te	31. Date filed (Month, Day, Year)		Registra s Signa	ture	1	0				- 1	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ELLA HICKERSON LEWIS 2009 AM November 10:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care & Rehabilitation Ctr. Frederick Frederick 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Funeral 1□ M 2□ F Months Days Hours Min 216-44-2786 92 11, 1917 Director May Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1√2 Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1506 West 9th Street 21701 23a U.S.A. Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: White þ 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Secretary U.S. Government 7 is marked other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be i Health and Mental Lindsay R. Hickerson Clara Hickerson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Hornets Nest Court, Charles Town WV 25414 Ted Lewis / Son permit. Pages 1 and Department of Health: Important: If Item 27 any injury or other tr once. 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/9/09 Mt. Olivet Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service License ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final HEART FAILURE **Physician** ONGES disease or condition resulting in death) ハロソく /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 **⊒**•No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 □Yes 2 □No investigation 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifier DOO 61410 MD NOV, 09, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 TOLL HOUSE - HL, FREDERICK SYED GAFFAR 801 31. Date filed (Month, Day, 32. Registrar's Signature State backe Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Frances M. Langford 00 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WIC Roba SbyR YAULS. 1 OM/CO mal 7. Age (ii. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 01/22/1911 9. Birthplace (State or Foreign 5. Social Security Number (In yrs. last birthday, **Funeral** Min. Months Days Hours 214-32-0404 1 M 2 X F Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1109 Schumaker Drive, Apt. 103 21804 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🕱 No white Specify: þ 3 X Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) librarian public library 8 land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Alonzo Moore Mary Ella Jones ပ္ Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dashiell/nephew 30088 Stoneybrooke Dr., Salisbury, MD 21804 Department of Heal Important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Parsons Cemetery 11/12/09 Salisbury, MD Signature of Funeral Service Lic 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Kan disease or condition resulting in death) er. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transi sate has been signed by the attending physician and page 2 should be detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 🗆 No 2 11No 1 Tyes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 1€10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural s after dea. 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral D To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of cortifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Year)

NOV

12

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 11 5:24 Ronald Phillip Lashbaugh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Allegany** Frostburg 262 West Mechanic Street If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5-19-1940 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M M 2 □ F Maryland Director 69 219-34-6068 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Wodiest Evanitation must be notified at 1 MYes 2 No Director MD Allegany Frostburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 262 West Mechanic Street 21532 U.S.A. by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🕱 No Specify. Specify 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tire Builder Tire is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Bloom Margaret Lashbaugh Robertson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a.
Important: If item 27 is
any Injury or other trau 262 West Mechanic St., Frostburg, MD 21532
ce of Disposition (Name of Date 20c. Location - City or Town, State _wife Colleen Lashbaugh 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Cumberland Crematory | 11-27-2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Sowers Funeral Home, P.A. Sower MIGA 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown icate has been ; page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 No 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1∐ Yes Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 2010 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: completely filled in by the funeral

State

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier

29b. Signature and

30. Name and add

31. Date filed (Month, Day,

WINDLA JR.

PHYSICIAN

ress of person who completed cause of death (Item 23a) (Type, Print)

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number
D50844

29d. Date signed (Month, Day, Year)

MD 912 JETEN DRIVE CUMBINIAND, MD

DHMH 17 Rev 1/2001 Dr

State

Registrar

31. Date filed (Month, Day, Year)

Parko

Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 38473 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 1-200° HOMAS LEE 7:55 AM™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGAN 20 ARCH STREET CUMBERLAND 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Yea Aug 20, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 M 2 □ F Months Days Hours Min 110-28-5977 78 Director 1931 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Modical Evolution institute to notified at once. MD Allegany Cumberland Director 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Arch Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No If Yes, Give Year or Dates: Specify: þ Specify: Korea 3 Widowed 4 Divorced white Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) steel worker Iron Workers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Lee Lear Mildred Pauline (Cooper) Lear ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Lear wife 120 Arch Street Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Old Bethel Cemetery 11/28/2009 WV Romney 4 □ Donation ⊅ □ Øther (Specify) 22. Name and Address of Funderal Home, PA 21. Signature of Funeral S-rvice Licer see 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RCI Immediate Cause (Final a Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the_ attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the detached i 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 🗆 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1100 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number N. Opis Tami 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NINCILIAN DAISPANI 500 MEMORIAL AVE CUMB. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ALVERTA S. LIMING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Examiner 4c. County of Death Town, or Location of Death AR If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 O / 8 / 1 9 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. Maryland 212-20-0714 **Director** 92 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Harford Street 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or Funeral 731 Cherry Hill 21154 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ed Forces? Yes 2 No Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates, 1942-45 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify:White Completed 3 Widowed 4 Divorced er than "natur , the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Civil Service permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Famous 17. Father's Name (First, Middle, Last) 0 Wilton Leroy Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia S. Martin/Sister 2648 Dublin Road, Street, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Emory Cemetery 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 11/23/09 Street, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA17314 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Interval Between Onset and Death COMMany Immediate Cause (Final Physician disease or condition Medical resulting in death) or as a consequence of Examiner W Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or linjury that initiated events The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown Yes 2 No Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rozdian 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an Were autopsy findings available prior to completion death? this certificate Yes 1 Yes 2 1 No Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 Yes within 24 hours after death To the Funeral Director: A Accident
Suicide Investigation Could not be 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Daite signed (Month. Dav. Year) 20 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) Mn SWP ewis

DHMH 17 Rev 7/2009

State Registrar 31. Date filed Month, Day,

4

09-08882 John Thomas Lucas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene								
State rar	Certificate of Death	Reg. No. 20	S. Time of Deetin 475					
Dedent's Name (First, Middle,Last) John Thomas Lucas Jr.		November 15, 2009	1740 hrs					
acility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	1					

III THOMAS 23		For State Cert	ificate of	Death		Reg	. No.	200	9 301.
Physicia	in/	1. Decedent's Name (First, Middle,Last) John Thomas Lucas Jr.			2	Date of Death Month November	Day Y	ear 3. 1	Firthe of Death ○ → 1740 hrs
edical Exami		4a. Facility Name (if not institution, give street and number)		y of Death					
		1201 Maple Terrace Avenue Apt. 405		4b. City, Town, or Location of Death Brunswick 4c. County of Frederick					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		8. Date of Birth	(MM/DD/YY	1Foreign			
Director		218-78-1767 1x 2 F 49	Months Days	Hours Min.	May 25	, 1960	Countr	y) MD	
ń		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Locat	ion				10	d. Inside City Limits
J. F. F. F. F. F. F. F. F. F. F. F. F. F.		MD Frederick Branswick							
Maryland 28a-f show any d at once.	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of	What Country	?
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15-0036 filled within 72 hours after death with the Maryland I Hygiene d other than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		as Decedent of Hisp es, specify Cuban,				ce - American nite, etc.	Indian, Black,
or death	핕	Never Married 2 Mainted 1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year	1	Yes 2 X No	snecify:		Specif	w White	
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003(within iene.	dmc	12 17. Father's Name (First, Middle, Last)	Ro	ofer .	18.Mother's Name (First Middle M		struction	<u>n</u>
21215-0036 Mental Hygiene. marked other than	Be C	John Thomas Lucas Sr.			Joan Mari			,	
21215 ould be file I Mental H i marked ie event, t	To E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stree	t and Number or Ru	ural Route Numi	ber, City or T	own, State, Zi	p Code)
MD nd 2 sho alth and m 27 is aumati		Joan M. Ingersoll (mother)		Box 168 sition (Name of cer	Delray, W	7 <u>26714</u> Date	20c. Locatio	on - City or To	wn. State
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 Ruriol 2 V Cremetion 3 Removal from State	crematory or o			/17/09		stown, m	
timent rtant:	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Liceasee	0	Name and Address		Kee Fune			J
Baltimore, MD 2121: permit. Pages Halata 2 should be fil Departient of Halata 2 should I Important: If iten 27 is marked Injury or other traumatic event.	ik g	() (Xila)	1	Р	.O. Box 270) Augusta	a, W 26	5704	
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		or condition resulting in death) Due to (or as a consequence or b. Cardiome aly	†):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause	f):						
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876 tificate ng phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of preg		etal death 3	Ectopic pregna	ncy	Mont	-	y Year
Box 68: e death certifi the attending ed for use as	sician/	1 Yes 2 No 9 Unknown 9 Unknown	eath 5 (Other (Specify)			1		
that the death	Phys	Part II. Other significant conditions contributing to death but not r	esulting in the	underlying cause	given in Part I.	23e. Did to	bacco use c	ontribute to the	e cause of death?
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tal Reco dan: The law certificate has	l mo					1 Yes	rmed? 2 No	death? 1 ✔ Yes	2 No
ial Filan: 1	Be C	25. Was case referred to medical examiner? Hospital: 1 Innation: 2			e of Death (Check			0 - 4 011 1	
1 of Vital Rec fing Physician: The I After this certificate I funeral director, page	[2	1 Yes 2 No Pospital: 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatie		ury at Work?	g Home 5		6 Other: Scurred	
Division of Vital ral or Attending Physician: 1s after death. al Director: After this certiled in by the funeral director	i.i.	1 X Natural 5 Pending (Month, Day,Year)			Yes 2 No				
/iSiC r Atte ter dea irecto	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At h	nome, farm, st	reet, factory, office	building, etc.	28f. Location (or Town, 5		umber or Rura	Route Number, City
Div pital o ours af eeral D	Certification:	4 Homicide determined (Specify)							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowled one) Wedical Examiner: On the basis of examination a	dge, death occ and/or investig	curred at the time, og gation, in my opinio	date and place, and in, death occurred a	due to the caus at the time, date	se(s) and ma and place, a	nner as stated and due to the	i. cause(s)
To t	Medical	29b. Signature and title of certifier		29c, Licen				signed (Mont	
		his his, no		0.0	.M.E.		Novem	ber 16, 200	09
		30. Name and address of person who completed cause of death (Iter			115 6:00:		1		
		Ling Li, MB 7 tooletelit market		eet, Baltimore,	, MD 21201				
Regi:	State stra		. Som	flet					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38476 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2009 6:30 Α LEONARD November Medical JAMES 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🔀 M 2 🗆 F (Month Bay, Year) 20 Pennsylvania 89 May Director 164-18-2645 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be I Funeral 21701 United States 2520 Waterside Drive <u> Unit 117</u> Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Interest of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 □ Divorced Completed Year or Dates. 1942-1945 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) United States Department Elementary/Seconday (0-12) College (1-4 or 5+) of Defense Financial Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Margaret McGettigan Thomas Leonard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 310 Kenwood Court, Walkersville, Maryland 21793 Christine Hodges / Daughter item 2 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott November 1 X Burial 2 Cremation 3 Removal from State Quantico National Cemetery: 4 Donation 5 Other (Specify) 2009 Triangle, Virginia 21. Signatule of Funeral Service Licensee Z2. Name and Keeney 106 E. Name and Address of Facility Peney and Basford PA Funeral Home, 16 E. Church Street, Frederick, Maryland MO1473 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 4 Pregnant 9 Unknown Pregnant at time of death Yes 2 No s been signed by the s should be detached 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? 2 😿 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending 1 X Natural work' 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital ithin 24 hours after death.

the Funeral Director: A properted filled in by the fu within 2 To the

DHMH 17 Rev 7/2009 2)1

Medical

State

Registrar

29a. Certifier

29b. Signature and title of certifier

Myung Hee Nam,

UKCU

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 09

29c. License number

D35106

400 West 7th Street, Frederick, Maryland 21701

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland / [Departm <i>Certific</i>				0.0	000	00177
			Registrar 1. Decedent's Name (First, Middle, Last,		Certino	ale of L	Jeani	2. Date of Dea	eg. No.	1119	3. Time of Death
	Physicia	an						Month	Day	Year	11:55 A ^M
r	/Medic	al 🚚	Allen Leonard	Murphy		Sib. Tours or	Location of Death	Novembe		2009 ty of Death	11:33 A
	Examin	er	4a. Facility Name (If not institution, give	ŕ					Garı		
	~		504 Shenandoah Ave				ake Park If Under 24 Hrs.	8. Date of Birth			ace (State or Foreign
	Funeral Director			M 2DF	Yrs. Mon		Hours Min.	(Month, Day Feb. 2	, Year)	Coun	Virginia
			Usual Residence of Decedent	81				reb. 20	3 1720	West	VILGINIA
	hand ow	İ	10a. State 10b. Counfy	10c. City, Tow	n or Location					1	0d. Inside City Limits
	Mary -f sh fied	ţ	MD Garrett	Mtn.	Lake I	Park					1XYes 2□No
	r 28a	Director	10e. Street and Number	101	. Zip Code		1	0g. Citizen o	What Coun	try?	
	3a o		504 Shenandoah Ave	enue		21550			Unite	ed Sta	tes
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was D	ecedent of Hi	spanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-	14. Ra	ce - Americ	
٥	after or ite nine		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Xi Yes 2 □ No If Yes, Give		es 217 No	Specify:	nican, etc./		ack, White,	etC.
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ر ک	72 hc natu lical	Completed	15. Decedent's Edu (Specify only highest grad		. Decedent's (Give kind o	f work done o	during most of work	ing I	16b. Kind of	Business/Ind	lustry
7	thin an "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		OT use retired)				-1 3//
7	filed with Hygiene. ther thai	Co	8		Labor	er					oal Mine
Maryland 21215-0036	2 should be filed and Mental Hygis Is marked other aumatic event, ti	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surna	ime)	
<u>8</u>	should band Meni s marked umatic e	ဥ	William H. Murphy				Lucy Bo				
<u>a</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a, Informant's Name/Relationship (T)	,		,	and Number or Rui				Code)
2	es 1 and 2 of Health of Item 27 i		Dennis A. Murphy,				ard Road,	Oaklan Date			
Baltimore,	Jes 1 F of He	- 5	20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ F	Removal from State	of Disposition ery, crematory	or other plac	^(e) 11/17	/2009	20c. Location	i - City or I c	wn, State
Ξ	permit. Pages 1 Department of H Important: If Ite any injury or ot		4 □ Donation 5 □ Other (Specify)	Pleas			emețery			and, M	
ğ	epart spart sport ny inj		21. Signature of Funeral Service Licens	ee	22. Nam	ne and Addres avid A	ss of Facility • Burdock	Funera	1 Home	, P.A.	
I)	205 20		Katherine &	Jueizer	2	1 N. S	econd St.	, Oakla	nd, MD	21550	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	ications that caused the death. Do ne cause on each line.	not enter the	mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
برس	Physician		Immediate Cause (Final disease or condition	GASTRIC	CANO	ec				1	5 month.
1	/Medical		resulting in death)	Due to (or as a consequence	of):						
	Examiner		Sequentially list conditions	b							
	P ≓	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
Ď,	e exe	ũ	resuming in death) East	Due to (or as a consequence	e or):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical		d			<u> </u>				
9	as ∰	Physician/Med	IF FEMALE:								
Rox	res that the death cer igned by the attendir be detached for use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal deat		oic pregnancy	,			Date of delive Month	ery Day Year
	e deg	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Othe	er (specify)					
л О	that the ed by th detache	Ph y	Part II. Other significant conditions co	ntributing to death but not reculting i	in the underly	ina cauca aiv	on in Part I	23a Did to	hacco use co	intribute to t	ne cause of death?
	res the	by	Hypertans		in the discerny	ing cause giv	on in raiti.	1 🗆 1			
5	law requires as been sign 2 should be	Completed	11-17-6/18/031								, abril
Ö	has by	ple						24a. Was autop	sy	prior to co	psy findings available mpletion of cause of
r =	Th ate pag	Son						perfo 1⊟ Yes	rmed? 25⊠No	death? 1 ☐ Yes	2 🗆 No
<u> </u>	yslclan; The is certificate hadirector, page	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)		
or Vital Records,		5 I	1 Yes 2 XNo		outpatient 3[4 □ Nursing H	ome 🔁 Resid			y)
ם	ding Ph n. After th funeral	ä	27. Manner of Death 1★Natural 5 □ Pending		Time of Injury	28c. Injur Wor		28d. Describe h	low injury occ	urred	
Division	eath.	Certification:	2 ☐ Accident Investigation		M		Yes 2 □ No				
Ë	or Att	ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, for building, etc. (Specify)	farm, street, fa	actory, office		28f. Location (S City or Tox	Street and Nui vn, State)	nber or Rur	al Route Number,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral				- 1 4	and a control					Anhad
	Hosp 4 hou Fune ely fil	ical	(Check only 2 Medical Exam	sician: To the best of my knowledg iner: On the basis of examination a							
	the I	Medical	one)	and manner stated.		29c. Licens	e number		29d. Date sig	ned /Month	Day Year)
	To wit	-	29b. Signature and title of certifler	/ Kickty an		_				3 (0 9	Day, rodij
		5	E CONTROL	1 10 700			30032				
	4	NA	30. Mame and address of person who	ompleted cause of death (item 23a)	(Type, Print)	Man or	CIAIN -	· 1	4/1/	100	NO 21550
			31. Date filed (Month, Day, Year)	32. Registrar's Signature	0 (//	10110	11/4/7/5	ve o	11 (67)	- (2)	16 51770
		ite	o i. Date lieu (Mollel, Day, Teal)	oz. i pogratiai a orginature		10					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day November 7, Physician 2009 CHARLOTTE SANDERS MAPLE 9:40 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🔽 March 16,1922 Washington D.C. 577-24-9562 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show ral", or items 23a or 28a-f shov 1 ☐ Yes 2 X No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 20879 United States 18713 Flower Hill Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔯 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2 🛛 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: White þ Yes, Give Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Montgomery County than Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager Public Schools marked other permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Sullivan Samuel Barnett Sanders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gaithersburg, MD 20879 18713 Flower Hill (Daughter) Carole Dix 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition November 11, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cem. Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home uction 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Veau disease or condition resulting in death) emen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician the burial P.O. Box 68760, Physician/Medical signed by the attending place as the detached for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 44 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

the

2

State Registrar 29b. Sanature

30. Name and ad

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Re

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:50 AM Cecelia Hope Morgan 2009 November 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 20081 Hickory Bottom Lane Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 75 September 6,1934 Maryland <u>21</u>5-36-4636 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 USA 20385 Woodlawn Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify. Specify: White 3 ₩ Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Delivery Person Auto Parts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Earl Jones Annie Louise Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20081 Hickory Bottom Lane Leonardtown, MD 20650 Donna Abell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 19 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 2009 Leonardtown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. ichae laroune P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cerebrolase days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d, Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 🗆 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed and burial-trar Box 68760. attending physician for use as the buria signed by the a o ۵. Records, page 2 should Division of Vital Physician: funeral director, After this

Exami Physician/Medical þ Completed Be Certification: To

Physician

/Medical

Examiner

10a. State

Funeral

Director

show

death with the

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination at the rectified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
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permit. Pages 1
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Important: If ite
any Injury or ot

Physician

/Medical

altimore, Maryland 21215-0036

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State Registrar

To the Hospital or Attending Pr within 24 hours after deauh. To the Funeral Director After th completely filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner' 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D54346

29c. License number

29d. Date signed (Month, Day, Year)

November 16, 2009

Chandra Sajja, M.D.

24035 Three Notch Road

Hollywood, MD 20636

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SC Gab

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:14 Cherie Ann McIntosh 17, 2009 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 42324 Calvert Circle St. Mary's Mechanicsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours 1 M 2 X F Months Days 56 566-88-9875 Director January 2, 1953 Washington Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, "in Medical Examiner must be notified at 1 ☐ Yes 2 X No Director St. Mary's Mechanics ville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20659 USA 42324 Calvert Circle Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗷 No Specify: Š Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bank 12 Personel Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iris L. Roantree (Burchfield) Arthur Snarr ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health a Important: If Item 27 is any injury or other trauonce. Middleburg, VA 20117 Maryea McIntosh / Daughter 118 N. Jay Steet 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 18 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, Virginia 2009 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** uon disease or condition resulting in death) /Medical (or as a consequence of): Examiner Solumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for Yes 2 No o 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 No 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No death. Director: 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

To the I within 2 eme

40900 Merchants Lane st. 205 Leonardtown, MD 20650 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Schmidt,

29b. Signature and title of certifier

30. Name and address

Jennifer

rson who completed cause of death (Item 23a) (Type, Print)

D.O.

H005575

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Francis John McD		Please Typ el, Sr. Sta For State	te of M	aryland	/ Depar	tment of	Health	and	Menta	l Hyg	iene	2	00	q :	8848
	R	egistrar	1 4)		Cert	ificate of	Deatri			12	Reg Date of Death	J. 140.		3. Time of D	
Physician Medical Examine	•	Decedent's Name (First, Middle Francis John		niel,	Sr.					1	Month November	Day Year 15 , 2009		1850 hr	
(4	a. Facility Name (if not institution 38390 Golden Beach F	, give street			4	b. City, Tow Mechar			Death		4c. County of St. Mary			
Funeral	5		6. Sex	7. A	ge (In yrs. la	st birthday)	If Under	1 Year	If Under 2	24Hrs. 8	3. Date of Birtl	(MM/DD/YYYY)	g. Birth	place (State	: or
Director	- 1		1X M 2	F	46	Yrs.	Months	Days	Hours	Min.	March	3, 1963	Foreign Cour	ntry)Mar	yland
any	_	Usual Residence of Decedent Oa. State 10b. County			10c. City.	Town or Locati	on						$-\tau$	10d. Inside	City Limits
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Maryland 28a-f show d at once.	⊃ L	0e. Street and Number					10f. Zip Code 10g. Citizen of W						at Count	ry?	
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003 withir giene. her th	Completed	12 7. Father's Name (First, Middle,	Last)			Dise	1 Mec	hani	LC 3.Mother's	Name (F	irst, Middle, N	Autom Maiden Surname		e	
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213 ould b d Men s marl	0	19a. Informant's Name/Relations	nip (Type, P	rint)					and Numb	er or Rur	al Route Num	ber, City or Tow			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygient from Important: If item 27 is marked other than injury or other traumatic event, the Medica	1	Cindy L. Mc	Danie	1/Wife	2 205 5	402 Place of Dispos	286 Wo	1f I	Orive		chanic Date	sville,	MD City or	20659 Town, State	
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Itim it. Pag riment rriant: y or o	1	4 Donation 5 Other St. 2). Signature of Funeral Service	ecify:				Name and A					Charl 1d-Echo			
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Physician	1	23a. Part I. Enter the disease, or failure. List only one cause	complication	is that cause	ed the death.	Do not enter t	he mode of	dying, s	uch as car	rdiac or r	espiratory arr	est, shock, or he	art	Approxim Between	ate Interval Onset and
/Medical caminer		Immediate Cause (Final disease or condition resulting in death)	a. Multi	ple Injurie	es nsequence o	n·							_	D	eath
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Box 68760, e death certificate be. the attending physicia of for use as the burie		IF FEMALE: 3b. Was decedent pregnant in ti			come of preg		ntot do oth	3	Ectonic	pregnan	CV	23d. Date of Month) Day	Year
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al Re		25. Was case referred to medica	1				2		of Death (Check or	nly one)				
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ivisior tor Attend after death Director:	Eat	2 🗸 Accident Inve	stigation	28e. Place o	f Injury - At h	ome, farm, stre	eet, factory,	office bu	uilding, etc			Street and Numi	per or Ru	ural Route N	lumber, City
Div ital or urs afte	Certification:		id not be		đajor Roa						or Town, 8390 Golde	State) n Beach Road	, Mecha	anicsville,	MD
		29a, Certifier 1 Certifying F	hysician: T	o the best of	f my knowled	ige, death occu	urred at the	time, da	te and pla	ice, and o	due to the cau	se(s) and manne and place, and	r as stat	ted. ne cause(s)	
To the within To the complet	Medical	one) 2 Medical Exa 29b. Signature and title of certifi	and	manner state					e number			29d. Date sig			
		him	. v	S				O.C.N	И.E.			Novembe	r 16, 2	009	
	-	30. Name and address of person			of death (Iter	n 23a)									
19de)				al Exami		Penn Stre		nore, l	MD 212	01					
Sta Registr	ite ar	31. Date filed (Month, Pay) e2	009	32. Regis	strar's Signal	par	1								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\overset{\text{Day}}{1}3$, 2009**Physician** November 2157 McMahon Hilda Louise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Lexington Park 19015 Three Notch Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 21 F 09/10/1946 Nevada **Director** 63 043-42-7886 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Event and the profiled at 10a. State 1 ☐ Yes 2x No Director St. Mary's Lexington Park Maryland 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with USA 20653 19015 Three Notch Road Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ∐Yes 2XXXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 If Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) State of Maryland Childcare Provider Health and Mental Hygidem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clark Ragnheidur Jonjdotter William Η. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 629 Kingfisher Lane, Sarasota, FL 34236 <u>Cynthia E. Knight/Daughter</u> permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Charlotte Hall, MD 11/19/2009 Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Shawn Aylesworth M01521 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final **Physician** 1/25 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, a ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐Yes 2 No 5 Other (specify) P.O. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Hospital or Attending P 24 hours after death. Funeral Director: After t 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide e Funeral I

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

William Boyd,

25365 Point Lookout Road, Leonardtown, MD 20650 M.D. 2. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

II,

To the P within 2

[Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			Please	Type or Prin								
			For State	State of Ma	aryland /		artment of I <i>rtificate of</i>				200	0 20102
			Registrar 1. Decedent's Name (First, Middle, Las	st)		001		Dealii	2. D	ate of Death	No. 2 U U	3. Time of Death
	Physic /Medi		Vada Mae Metz						N'	ovemb	er 6, 20	о а 33рм
A.	Examir	ner	4a. Facility Name (If not institution, give Memorial	e street and number)			4b. City, Town, o	r Location	of Death		4c. County of De	ath DOT
	Funeral Director		247-30-3301	ex	e (In yrs. last bi 2	rthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. D Min. 3	ate of Birth Mo <i>nth, Day, Ye</i> -2-192	9. B 7 S	irthplace (State or Foreign Country)
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Maryla I sho	ţo	Md Talbot		Sherw							1 ☐ Yes 2 X No
	with the 3a or 28a	al Director	10e. Street and Number 8139 Tilghman	Island 1	Rd.		10f. Zip Code 2166	55	<u> </u>	10g.	Citizen of What C	Country?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinal must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			Vas Decedent of H fYes, specify Cub			res or No- n, etc.)	14. Race - An Black, Wh	ite, etc.
Maryland 21215-0036	within 72 ho iene. • than "natur r v Medical	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5		(Give I	lent's Usual Occup kind of work done OO NOT use retire	during mos d)			Kind of Busines	·
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Baltimore	2 = E 2		Burial 2 Cremation 3 4 Donation 5 Other (Specify)	New S	Silv	ver Bro	ok	11-15-		nderson	-
Ba	permit. Departri Importa any Inju		21. Signature of Funeral Service Licen	An Amila	1.F S.A.	R.		11 Hu	urley	Funera	al Home	, PC
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do		. U. BO	$X \rightarrow I$	S. ST.	_ Micha	aels, M	Approximate Interval Between
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	ited nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a	consequence	of):	Man.	Pa	don	DL	0	51,
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	icate by physici the bu	dical		d								
O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medica	iF FEMALE: 23b. Was decedent pregnant in the past 12 rpentits? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the line of the l	2 🗌 Fetal death		Ectopic pregnand Other (specify)	су			23d. Date of de Month	elivery Day Year
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Records,	Physician: The law r this certificate has t ral director, page 2 si	Completed by	Gastro Esofles	e Dell	wen 1	gi ida	e e			4a. Was an autopsy performed □Yes 2 ☑	prior to	utopsy findings available completion of cause of
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Division of Vital	al or Atter s after dea I Director d in by the	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, fa . <i>(Specify)</i>	rm, stre			28f. Lc	ocation (Street ity or Town, St	and Number or F ate)	Bural Route Number,
	e Hospita 24 hours e Funera sletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of iner: On the basis of and manner sta	examination an	e, death	occurred at the tire estigation, in my o	me, date an opinion, dea	nd place, and di th occurred at t	ue to the cause the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	. /	, 1 1	10	29c. Licens	e number		29d.	Date signed (Mon	(h, Day, Year)
>	TLS		• Will	an It	Nood	1/1	() [788	-715		11/7/	59
	4		30. Name and address of person who or William It. Woo	empleted cause of de	eath (Item 23a) (Type, P	mans L	ane	East	onn	1d 2110	0/
	Sta Registra		31. Date filed <i>(Month, Day, Year)</i> NOV Q 9 20	32. Registra	r's Signature	de	mans L		,		- 6x / W	
			1101 0 0 2	Le person	- 1	a.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38484 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Day Physician/ 2009 2:00 P.M Dorothy Mav McAuliffe Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert County Nursing Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days May 22, 1924 1 □ M 2 👿 F Washington, DC 578-22-1020 Director 85 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🎇 No Friendship Anne Arundel 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral U.S.A. 20758 6520 Wilson Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2 XNo Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. white 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DC government social worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Theresa McAuliffe Nellie Flanagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6520 Wilson Rd., Friendship, MD 20758 Rosemarie McAuliffe, sister-in-law Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 11/16/2009 Suitland, MD ature of Funeral Service Lick 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** mer Sequentially list conditions, Due to (or as a consequence of if any beding to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VASCULAR DISEASE, PERIPHERAL 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? DECUBITUS VICER 24a. Was an autopsy 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 100 1 Inpatient 2 ER/Outpatient 3 DOA ည fursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Watural 5 Pending work?
1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2009 50233 30. Name and address of person who completed cause of reath (Item 23a) (Type, Print) dru 3 2067 PINCE FREDERICK, MD HUSSIML DRIVE

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Registra s Signature

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 November Vernon Main Martin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick 5337 Reels Mill Road Frederick 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours June 15,1936 Maryland 218-34-2828 Director 73 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, the Medical Examinant result be notified at 1 ☐ Yes 2 X No Director Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with United States 5337 Reels Mill Road 21704 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2XINo Specify: Specify: Completed by 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Martin Trucking Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Laura Naomi ဥ Roscoe Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is eny Injury or other treu once. 1788 A Poolside Way, Frederick, MD 21701 Cia Lare / Daughter 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 □ Burial 2 □ Cremation 3 □ Removal from State Olivet Cemetery 10/11/2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 our 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Esophaeal **Physician** CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): 3425 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical « esn IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown s been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed The After this certificate I funeral director, page 1 ☐ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 119 100 069310 Sunca New Mus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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LINDA CRUM MUEHI

NOV 10

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** John Randolph November 2009 12:00 Mason /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1⊠M 2□F Months Days Hours Min. 224-76-2845 60 2, June 1949 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5692 Ridge Road 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ⊠Yes 2 No
If Yes, Give
Year or Dates: Vietnam 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 2 Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Technical Writer 5+ Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Mason ျှ Mary Belcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia R. Mason / Wife 5692 Ridge Road Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 2009 Frederick, Maryland 21. Signature Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part 1. Enter the disease, or comshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase of Light) that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≲</u> 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ∧1 ☐ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.O. Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit ed by the attending physician detached for use as the buria signed by page 2 should been has within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pagr

Funeral

Director

or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, It a Medical Exprision required any pince.

Physician /Medical

Examiner

and

Baltimore, Maryland 21215-0036

death with the Maryland

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D0061755 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD WESTMINSTER MD 21157 MD 700 A POOLE Maganna 31. Date filed (Month, Day, Year) NOV 1 () State 2009 Registrar

and manner stated.

29a Certifier

29b. Signature and title of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1^{Month} Physician/ 30^{Day} Ethe1 Virginia 2006 5:52PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3915 Old Birdsville Road Harwood Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 - M 2XX Months Davs Hours Min. Washington DC Director 92 214**-**38-7904 Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Harwood 1 Yes 25 X No 10e. Street and Number 10g. Citizen of What Country? Funeral filed within 72 hours after death with 20776 3915 Old Birdsville Rd. USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 0 1 Never Married 2 Married Completed by 1 ☐ Yes 2√13 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X X No Specify: White permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK David Teg Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harwood, MD 20776 3915 Old Birdsville Rd. Virginia Owens Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 11/4/2009 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State Brentwood, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, Chr Satul 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Failure Physician/ disease or condition resulting in death) Medical Due le lor as a consequence of Examiner Sequentially list conditions, Due to or as a consequence of): if any, leading to immediate cause. Litter orderlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) Year ed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X/10 မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifia ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Che Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

State

Registrar

3168

Braverton Street Suite 250 Fedgerate, MD

30. If me and address of person who completed cause of death (Item 23a) (Type, Print)

Marcakis

NOV 09

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38488 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ 8, 2009 William J. MacQuilliam 1:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral 69 Director 262-56-7488 1940 Washington, Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏝 No Maryland Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 Funeral USA 856 Saint Edmunds Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Self Employed Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph H. MacQuilliam Alice Marie Rehrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shari S. MacQuilliam/ Wife 856 Saint Edmunds Place Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 11-9-2009 Edgewater, Maryland 5 Other (Specify) 4 Donation 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Esophagea Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Pospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No sate has been signed by the atte page 2 should be detached for Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ٌ🌣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

31. Date filed (Month, Day, Year) **NOV 09** 200B Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, 1

29b. Signature and title of certifier

32. Registrar's Signature Jarke

29c. License number D46052 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygien 🗸 U

1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** AM 6617 MOORE 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury STREE comico 615 Booth If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days 85 1 ⊠ M 2 □ F 05-3050 Director MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Xes 2 No N) aculand SALISBURY (1): comico Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Booth REE USA 21801 or items 23s Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 BYes 2 DNo 1Yes, Give Year or Dates: 1943-45 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.

le marked other then "naturel", or ite. 1 Never Married 2 Married 1 ☐ Yes 2000 Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WAITER NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Mieddle, Maiden Sumame) Be Moore WATERS OMNUE LAURA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 shr Depertment of Health and Important: if item 27 ie m any injury or other traum: QDCs. 19a. Informant's Name/Relationship (Type, Print) ucille NIBORE -MARUJAND 21801 Beoth 20b. Place of Disposition (Name of cometery, crematory or other place)

No EASTERN Share VA (EN) 20c. Location - City or Town, State 20a Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State 11-19-09 4 ☐ Donation 5 ☐ Other (Specify) HURLOCK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOME SZ TUNERA, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 4 647 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician end detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ostern this 24a. Was an this certificate has autopsy performed? 25 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medicat examiner? filled in by the funeral director. 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Maturat 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HAVE Phy SICIAN Dec 52255 CON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Constiel ge chesa feate 30 Dr. Muhammad EJAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 16 arke 2009

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036 Baltimore, **Physician** Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours a To the Hosp within 24 hou To the Funer completely fil Registrar

State

29b. Signature and title of certifier

1)001 8410

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Huram WAMO 80 31. Date filed (Month, Day, Year) NOV 12 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien & U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov. **Physician** 4:40 PM 2009 Viola Estelle Margroum /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Frostburg Village Asst. Living Frostburg 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 € F 86 217-12-5644 Maryland Director 22,1923 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 28a-f show d other than "natural", or Items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 ∏Yes 2X No Director Frostburg MD Allegany 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21532 USA 100 Village Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 □Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White ģ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than traumatic event, the We Elementary/Secondary (0-12) College (1-4or 5+) Restaurants 9 Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred V. Bosley ၉ Hiram O'Neal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 11007 Ramblewood Dr NW, LaVale, MD 21502 Nancy Small, daughter permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. once. 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Wesley Methodist Dec.2,2009 Hampstead, 4 ☐ Donation 15 ☐ Other (Specify) 22. Name and Address of Facility Hafer FUneral Service, 21. Signature of Funeral Service Licensee x hon 1302 National Hwy, LaVale, 23a Pgrt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heari failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 montto Due to (or as a conse uence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): burial-transi Due to (or as a consequence of): Box 68760. attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown icate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑Ño 24a Was an autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. funeral director. this death. 24 hours after death Funeral Director: filled in by

1 Yes 2 XNo

27. Manner of Death 5 Pending investigation Natural 2 Accident 6 ☐ Could not be

3 Suicide 4 Homicide

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

wowoelsthe

28a. Date of Injury (Month, Day, Year)

29c. License number

D0055325

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wonsock Shin 925
31. Date filed (Month, Day, Year) Bishop Walsh Rd, Cumberland, MD 21502

State



28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

completely

within 2 To the I

Medical

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles Nasby Murphy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ALLEGA. WMHS-RM 8. Date of Birth (Month, Day, Year) Aug. 20,1948 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Country)
Willard, 1 🖾 M 2 🗆 F 61 Aug. Director 301-40-5607 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedio... Examinar must be notified at 1 ☐Yes 2 No Director WV Mineral Keyser 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 2 should be filed within 72 hours after death with and Mental Hygiene. Fried Meat Ridge Road 26726 Funeral Rt. 6 12. Was Decedent Ever in U.S.
Armed Forces?
1 MYes 2 □ No
If Yes, Give Vietnam
Year or Dates: War 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced War Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) (GED) 12 Officer -US Navy U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Robert Murphy Maxine Delora Junkins ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar 27 26726 Susan E. Murphy/ Wife P.O. Box 1053 Keyser, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of
important: If it
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory 2009 Cumberland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Smith Funeral Home Buen 1 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 346 CENEDROVER CUlas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the deeth certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 No 1 ☐Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/ NO 112 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral c Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 1 Yes 2 🗌 No 24 hours after death. Pruneral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SANKOMMU SUPHEER ٥

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State

Registrar

CUMBERLAND, MO-21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 0 2

Low BRook

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 38493 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter Edward III Meuse November 25,2009 1:00 pmM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 429 North Market Street Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 212-80-9792 1 X M 2 D F Hours Augon29ay1938 Marvland 51Yrs **Director** Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Frederick Frederick 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 429 North Market Street 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 X No If Yes, Give Year or Dates. Black, White, etc. þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 'natural", Completed 3 Divorced 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Kennel Technician 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Animal Control Center Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Edward Jr Meuse Margaret Estella Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Gray/Executor 425 N Market Street, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🛣 Removal from State Hollinger Crematory Mt. Holly Springs, Nov. 27, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens se Keeney & Basford Funeral Home Frederick MD 21701 22. Name and Address of Facility 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death TheroschenoTIL CARDIO VASCULM Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been si irector, page 2 should 1 24b. Were autopsy findings available prior to completion of cause of death? performed 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0035152 11.25 09 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD Thus Toharra Prive Krans MO 8 Ú Day, 32. Régistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38494 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOV. 24, 2009 11:30A M ROBERT BOSTWICK MORGAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES FT. WASHINGTON FT.WASHINGTON HOSPITAL 8. Date of Birth (Month, Day, APR . 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country)
MICH 1 1 M 2 | F Director 722-03-6549 82 ,192 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director PRINCE GEORGES ACCOKEEK 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15512 CEDAR DRIVE 20607 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No NAVY Maryland 21215-0036 1 ☐ Yes 2 🙀 No WHITE Specify: WWII Completed 3 Widowed 4 Divorced Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than NASA-GODDARD College (1-4 or 5+) Elementary/Seconday (0-12) TECHNICAL INFORMATION SPEC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I tem 27 is marked o EDWIN REED MORGAN ALBERTA BOSTWICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ACCOKEEK, MD. 20607 VELMA MORGAN-SPOUSE 15512 CEDAR DR. Page 1 and 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 11-26-09 ALEX. VA Signature of Fuperal Service Licensee 22. Name and Address of Facility M00479 Marc RAYMOND FUNERAL SERVICE, P.A. PLATA MARYLAND 26646 mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication that caused the death. Do not not shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 SS IF FEMALE yes, outcome of pregnancy ase 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗀 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer erson who completed cause of death (Item 23a) (Type, Print) State

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Registrar

35

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** Mattie Melissa-Morehead 6:40A November 14, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** St. Elizabeth Nursing Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 □ Director 240-40-8726 89 March25,1920NorthCarolina Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar rust be notified at Yes 2 □ No Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Benson Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ No Specify: Specify:Black þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental ဂ Marvin Brooks <u>Mattie Reaves</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 4 0 8 2 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra 5039SW Widgeon Way, Lee's Summit, Missouri Glendia Hatton/Daughter Pages 1 gment of Hr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Guilford Mem.Park 11-20-09 Greensboro, N.C 22. Name and Address of Facility Marzullo Funeral Chapel P.A. 21. Signature of Funeral Service Licensee michael 1. margullo 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or convilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner h-poth-roidism Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner エフン Due to (or as a consequence of) Box 68760, that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 ☑No o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 ☑No **Division of Vital** Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R111615 11/14/09 Jenni fer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greidsbornigh AVE 3320

State Registrar 31. Date filed (Month, Day, Year)

T

32. Registrar's Signature

25. Was case referred to medical

autopsy performed? Yes 2 2 No 1 □ Yes 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Hospital: 1 M Inpatient 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 5 Pending investigation 1 Matural 2 ☐ Accident

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide 4 Homicide

> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D 0064478 29d. Date signed (Month, Day, Year) NOVEMBER 7, 2009

2 🗆 No

mellaci

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Md.

State Registrar

Fisehatsion Mehari, M.D. 32. Registra Signature 31. Date filed (Month, Day, Year) 2009

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certificate

this

After 1

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending

funeral director,

Be

Certification: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 5:45 a.m. James Henry Neugent III November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 X M 2 □ F 10/22/1944 Washington, Director 031-32-4863 65 DC Usual Residence of Decedent 10d. Inside City Limits or items 23a or 28a-f show 10h County 10a, State 10c. City, Town or Location 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland St. Marv's Lexington Park 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20653 21576 South Essex Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Engineer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Josephine Teresa Butts James Henry Neugent, Jr. Department of Health and M Important: If item 27 Is man any Injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42020 Starlight Drive, Leonardtown, MD 20650 James H. Neugent, IV/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 11/17/2009 Charlotte Hall, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Shawn Aylesworth 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Physician/ disease or condition Medical resulting in death) Days Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): iis certificate has been signed by the attending physician director, page 2 should be detached for use as the buriar Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of the IF FEMALE: 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute sesperatory Forlesse 3 Probably 4 Unknown 2 🗌 No mec Obs Tructore Long disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 5 epses 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♠ No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie en. Federle mo pro 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVIR M Federe; 24035 Three North Mono, Holly wood, me JAVIR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 38498 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2.5 2009 David E. Nickle Nov. 3:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Liberty Gardens Elder Care Conowingo Cecil 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-29-1918 Birthplace (State or Foreign Country)
 P A **Funeral** Days Hours Months 480-03-2310 91 Director Yrs Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Evantrae nust be notified at cecil Director MDRising Sun 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or items 23a 12 Sun Valley Circle death v 21911 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1☐ Yes 🙀 No þ Specify. 3X Widowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) Custodian Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Nickle Edna Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an tant: If itam 27 is giveny or other traur Grace L. Shoff Daughter 12 Sun Valley Crc. Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any njury or once. 4 ☐ Donation 5 ☐ Other (Specify) Oxford Cemetery 11-30-09 Oxford, PA 22. Name and Address of Facility Edward L. Collins Funeral 21. Signature of Funeral Service V cens Home, Inc. 86 Pine St. Oxford, PA 19363 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION Physician PNEVUDNIA disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner DUSPIAGIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner STRIKE Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ρ in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Cther (specify) P.O. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. SENILE DEMENTIA 4 Unknown Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably CMRONIC KENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No ASSISTED. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this LIVING PA Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending death. after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) tha 29b. Signat 29c. License number 0 29d. Date signed (Month, Day, Year) MD 0066323 30. Name and address of person on pleted cause of death (Item 23a) (Type, Print) MOUR 281 E. HING SUN, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State barke Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ann Oliver Audrey November 9,2009 2:37 A^M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 1□ M 2 F Days Hours Min 217-66-2274 66 June 4,1943 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 24678 Maddox Road 20621 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 → Married 1 Nes 2 No If Yes, GiveX Year or Dates: 1 ☐ Yes 2 🕱 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Oscar Clements Edna Malinda Herbert 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Oliver/Husband 24678 Maddox Road, Chaptico, MD 20621 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holy Ghost Cemetery 11/13/2009 4 ☐ Donation 5 ☐ Other (Specify) Issue, Maryland 21. Signatur V Funeral Şervice Licensee 22 AREHART ECHOLS FUNERAL HOME, P.A. aur 211 St. Mary's Ave. La Plata.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Minutes Due to (or as a consequence of) branic Ren Sequentially list conditions, if any leading to firm adults cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conscouence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 → No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X**No 2 No 1 □ Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

Examiner Examine certificate be executed physician and s the burial-trans attending properties as ed by the signed by has page 2 s this certificate director.

After t

Director:

Medical

the Hospital or Attending hin 24 hours after death.

24 hours a

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of Vital Recofds,

Division

Physician

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Examiner

Director

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It. Medical Examination must be positified at

Baltimore, Maryland 21215-0036

Physician/Medical ð Completed Be Certification: To

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

4 Homicide 29a. Certifier (Check only

29b. Signature and title of certifier

Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29d. Date signed (Month. Day. Year)

2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Name and address of person who completed cause of death (flem 23a) (Type, Print)

31. Date filed (Mönth, Day, Year)
NOV 12 2009

P.O. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylan	-	artment of tificate of		d Mental Hy	/giene Reg. No. 2	009	38500
	Physicia		1. Decedent's Name (First, Middle Harry James	o, Last) Ockershaus	en				2. Date of D Month Noven		2 00°9	3. Time of Death 6:40 a M
1	Medio Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Co									
	Funeral		Arden Courts A 5. Social Security Number	6. Sex 7.	ving Age (In yrs. la	ast birthday)	If Under 1 Year		Irs. 8. Date of Bi	rth	ontgon g. Birth	place (State or Foreign
	Director		577-38-4320 Usual Residence of Decedent	1 № M 2 □ F		100 Yrs.	Months Days	Hours M	reb. 2	3 ^{y, Ye} 1909	D.C.	ntry)
	yland f show ed at	ctor	10a. State 10b. County		10c. Cit	y, Town or Lo	cation	-				10d. Inside City Limits
	he Mar or 28a- o notifie	Director	PA - Pittsburgh 10e. Street and Number 10f. Zip Code 10g. Citizen of What								of What Cou	1 🗆 Yes 2 🏝 No
	h with t ns 23a	Funeral	113 St. Charl	es Court			15238	- <u></u> -		US		,
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show arm yinty or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Mai 3 X Widowed 4 ☐ Divorced	If You Give	es? No	1	Vas Decedent of I f Yes, specify Cub □ Yes 2√□ No	oan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ace - Americ lack, White, ify: Wh	
15-0	72 hou n "natu fedical	Completed	(Specify only high	nt's Education est grade completed)		16a. Deced	lent's Usual Occu kind of work done O NOT use retired	during most of v	working	16b. Kind of	Business In	dustry
212	within ygiene. her tha t, the I	Be Cor	Elementary/Seconday (0-12)	College (1-4 5+	or 5+)		orney					levision
land	l be filed fental H rked ot tic ever	To B	17. Father's Name (First, Middle, Harry Ockersh					18. Mother's I	Name <i>(First, Middle</i> rosnan	, Maiden Surna	me)	
, Mary	d 2 should raith and Ν n 27 is ma er traumal	- 68	19a. Informant's Name/Relations Jane Ockershau		er	19b. Mailir	ng Address (Street St. Cha	t and Number or rles Co	Rural Route Numb urt, Pitt	er, City or Town Sburgh	, State, Zip (PA 1	Code) .5238
Baltimore, Maryland 21215-0036	Page 1 an ment of He ant: If iten ury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3		ate c	emetery, cren	sition (Name of natory or other pla Memorial		Nov. 11, 2009	20c. Location	•	own, State
Balt	permit. Depart Import any inj	3	21. Signature of Funeral Service	Licensee	2	22	Name and Addr Francis 500 Univ	ess of Facility J. Coll	ins Fune: Blvd. W	cal Home	e Inc.	ng, MD 2090
	Coate be executed Medical Examiner sthe burial-transit	cal Examiner	23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if all y, leading the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sersi Due to (or b. Currls (or	line.	ience of):	er the mode of dyl	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death 1 day
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 🗀 Feta nt at time of c	Ideath 3	Ectopic pregnar Other (specify)	ncy			Date of deliv	ery Day Year
s, P.O	res that t signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia 23e. Did tobacco use contribution of the underlying cause given in Part I. 1									
ecord	e law require: e has been si; ge 2 should t	Completed								opsy ormed?	prior to co death?	psy findings available impletion of cause of
tal R	ysician: The law is certificate has director, page 2	Be Co	25. Was case referred to medical examiner?					Place of Death (C	Check only one)	2 X No	1 🗌 Yes	
Division of Vital Records, P.O.	iding Physic th. After this or funeral dire	ည	1 ☐ Yes 2 🛣 No 27. Manner of Death 1 ☐ Natural 5 ☐ Pendii 2 ☐ Accident Investi	28a. Date of	patient 2 injury Day, Year)	ER/Outpatien 28b. Time of injury	t 3 □ DOA 28c, Inju wor	ry at	g Home 5 Res 28d. Describe	idence 6 🗷 O		isted Living
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	al Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be 28e. Place of	Injury - At ho , etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (City or To		nber or Rura	Route Number,
	the Hospi hin 24 hou the Funer npleted fill	Medical	(Check 2 ☐ Medical I only one) 3 ☐ Certifying	Nurse Practioner: To	of examinatior	n and/or invest	igation, in my opin leath occurred at t	ion, death occurr he time, date and	ed at the time, date	and place, and o	due to the ca	use(s) and manner stated.
9	6+1		29b. Signature and title of certifie	M			29c. Licens	D4323	7	29d. Date sign		Day, Year) Der 9, 2009
			30. Name and address of person Paul Armstron					e, Laur	el, MD 20	707		
	Stat Registra	e ar	31. Date filed (Month Cav Year)	3 "75 11 36 1 1 203 "	istrar's Signat	ure.	and			-		

DHMH 17 Rev 7/2009